DOCUMENT RESUME

ED 219 125 PS 012 931

AUTHOR	Ouderkirk, Wayne, Ed.
TITLE	On the Line in Child Care: An Entry Level Training Curriculum for Residential Child Care Workers.
INSTITUTION	State Univ. of New York, Albany. School of Social Welfare.
SPONS AGENCY	New York State Dept. of Social Services, Albany.
PUB DATE	80
NOTE	400p.
AVAILABLE FROM	Sally Bordan, Publications, SUNYA School of Social Welfare, Continuing Education, 135 Western Avenue, Albany, NY 12222 ($8.50).
EDRS PRICE	MF01/PC16 Plus Postage.
DESCRIPTORS	Behavior Problems; *Child Caregivers; Continuing Education; Emotional Disturbances; *Entry Workers; Helping Relationship; Individual Development; *Inservice Education; Instructional Materials; Interpersonal Competence; Intervention; *Learning Modules; Needs Assessment; Postsecondary Education; Program Development; *Residential Care; *Training; Values
IDENTIFIERS	Self Awareness

ABSTRACT

A curriculum used over a 3-year period in statewide training programs for residential child care workers is organized and described according to 11 training modules. The modules focus on increasing the self-awareness of the human service professional and on presenting basic facts about human development, procedures for assessment and planning, and aspects of child care practice. Each module provides introductory material stating purpose or rationale, statements of behavioral objectives or behavioral changes indicating what the worker should be able to do after completing the module, resource papers for trainers preparing instruction, and training session outlines providing specific suggestions on how to deliver a training lesson on each topic. The training sessions are the core of the curriculum; these include a list of logistical requirements concerning time, space, equipment, handouts, and other needed materials, as well as a description of a proposed training session. Annotated bibliographies at the end of the modules are intended as an initial guide to the literature related to module content. In addition to a case example for use in the assessment and evaluation of training, a self-assessment form for trainees is included with the handouts for each module. (RH)

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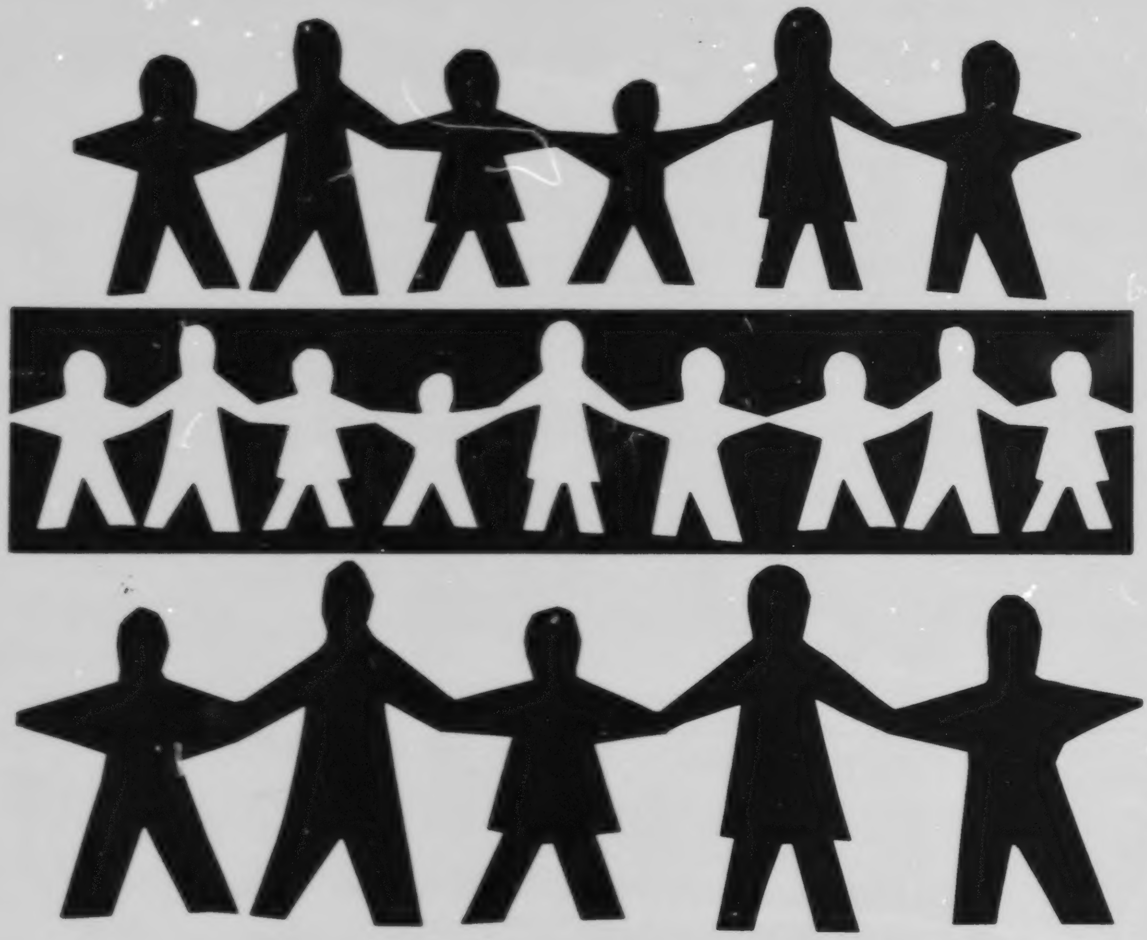
On the Line in Child Care:

AN ENTRY LEVEL TRAINING CURRICULUM FOR RESIDENTIAL CHILD CARE WORKERS



Continuing Education Program
School of Social Welfare
State University of New York at Albany

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Wayne Ouderkirk, Editor
1980

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SOCIAL SERVICES

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This document was produced under a contractual agreement between the New York State Department of Social Services and the Continuing Education Program, School of Social Welfare, State University of New York at Albany, through the Research Foundation of State University of New York.

CONTINUING EDUCATION PROGRAM

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ACKNOWLEDGMENTS

Although it may be impossible to express appreciation to all the people who helped in the development of this curriculum, I would like to try.

First, I have to thank the child care workers from the voluntary agencies of New York State who participated in the training sessions upon which the curriculum is based. Their comments, suggestions, activity, and criticisms helped improve this package immensely.

Next, I owe a debt of gratitude to those other staff members of the Social Services Training Unit of the Continuing Education Program, School of Social Welfare, who helped develop and deliver various prepublication versions of the training sessions. Naturally, these include my co-authors, Mary Armstrong, Mary Ellen Deighan, Patricia O'Donnell, Patricia Perfetto, and Anne Stea. In addition, many fine contributions came from Mary Altpeter, Brian Bentley, and Cheryl Ohanesian. Without the diligent efforts of Will Limer in collecting and analyzing evaluative data, many significant improvements could not have been made. Without typists, nothing gets printed. Joanne Bolduc, Mary Jean Porter, and Joyce Smith worked long and hard in producing myriad copies of the various parts of the document.

Peter Kasius and Richard Miller of the New York State Department of Social Services are to be commended for their patience in supporting the curriculum through publication.

Kenneth Skinner and member agencies of the New York State Council of Voluntary Child Care Agencies supported both the training program and the curriculum from start to finish.

The current president of the State Association of Child Care Workers, Brother Joseph Jozwiak, FSC, past president Jack Phelan, and the association's board of directors lent continued support to the child care worker training program.

I am especially grateful to Elace Comrie and Sue Gutbezahl for their successful efforts in associating the cover and module title page designs with the content. Nancy Koltko deserves commendation for compiling the bibliographies.

Finally, I would like to thank Sally Berdan and Roger Menges for editing the curriculum.

Naturally, any remaining faults in the following materials - and faults I am sure there are - are the responsibilities of the authors and editors, not of those others mentioned here.

If I have omitted anyone in this acknowledgment, I am sure that it is clear to them that the omission is unintentional.

Contents

Introduction 1

Case Example for Assessment and Evaluation of Training 9

Self-Awareness: Worker Style 25
by Anne Stea

Values, Values Clarification, and the Child Care Worker 47
by Wayne Ouderkirk

Human Growth and Development 67
by Patricia O'Donnell, Anne Stea, and Mary Armstrong

Loss, Separation, and Placement 107
by Patricia O'Donnell and Mary Ellen Deighan

Children, Families, and Child Care Workers 145
by Patricia O'Donnell, Patricia Perfetto, and Wayne Ouderkirk

Child Care Practice 207
by Patricia O'Donnell, Wayne Ouderkirk, and Anne Stea

- Goal Planning 209
- Teaching Alternative Behaviors 222
- Life-Space Interviewing 228

Building Therapeutic Groups 259
by Anne Stea

Activity Programming 291
by Wayne Ouderkirk

Developmental Problems of Adolescence 309
by Wayne Ouderkirk

Child Care and Cultural Differences 341
by Wayne Ouderkirk

Crisis Prevention/Intervention 357
by Anne Stea

Stress and Burnout 387
by Wayne Ouderkirk and Patricia Perfetto

CONTINUING EDUCATION PROGRAM

The Continuing Education Program, School of Social Welfare, State University of New York at Albany, offers instructional programs for staff of state and local departments of social services, staff of selected voluntary agencies, and other human service professionals. The target area for most programs is a 28-county region in northeastern New York; however, many programs are also conducted statewide.

Training programs are conducted by the following units: Income Maintenance/Medical Assistance, Social Services, and Management and Staff Development. An integral part of the program is the development of instructional materials for use in program training activities and for staff development in local districts.

Program administrators and staff work in conjunction with training and program staff from the New York State Department of Social Services and the local districts. Instructional materials, such as this publication, represent a product of this joint effort.

A NOTE TO THOSE WHO USE THIS CURRICULUM:

The training modules in this curriculum were used in statewide training programs for child care workers conducted over a three-year period. That use and the consequent refinement of both content and technique have produced what we, the trainers who developed the document, see as highly useful materials for the training of child care workers.

Following are some suggestions for the use of this curriculum. First, read the Introduction; it explains the format and content of the modules. Next, when you decide to deliver training on one of the topics, read that module before using it. That way you will know both the objectives it was designed to achieve and how to achieve them. You will gain a quick review of the topic and the literature on it through the resource paper.

After reading the module, you can decide whether the given objectives are your objectives, i.e., the objectives you and your workers wish to achieve. If not, you can write your own objectives and devise teaching strategies to achieve them. Even if you wind up with something radically different from what the written module proposes, it will have served its purpose by clarifying your own objectives.

In our biased opinion, however, we think you will find that the modules as presented provide clear and useful training for child care workers. It is our hope that they will be used and, when appropriate, improved upon. That is why they are presented to you. They will not solve all the problems endemic to residential child care work in New York State. But they will answer, in part, the need for a coherent and meaningful training experience for child care workers. If that much is indeed accomplished, those trained workers will be able to help solve many of the other outstanding problems.

INTRODUCTION

CHILD CARE

Residential child care work is a complex and difficult profession. Children who are delinquent, disturbed, abused, or neglected require deliberate and sensitive care, combined with astute assessment and realistic planning. Of course, the child care workers do not usually attempt these tasks alone; teachers, psychologists, social workers, and other professionals collaborate with the child care workers to form a capable team. Still, by virtue of both the amount of time spent with the children and the diversity of situations shared with them, the child care worker is responsible for a huge portion of the work to be done. To use that time and those situations constructively in promoting the emotional healing and growth of the children is a formidable professional challenge.

Surprisingly, most child care workers begin the job with little or no professional preparation; most of those who remain in the field receive an amount of training that is hardly proportionate to the demands of the job. Expertise is gained via experience, available training, and great personal effort. Although there are historical explanations for this state of affairs, efforts are beginning to alter it. There is still much to be done. This training curriculum is a contribution to that fledgling effort. Obviously, its use will not correct the problems that exist in the field. In terms of these problems, it is an aspirin rather than a miracle cure. Its use will alleviate some of the pains experienced by child care workers, but will not eliminate the causes of those pains. It is designed to provide training for beginning workers and supplementary and review training for experienced workers.

The training modules make no pretension of covering everything the child care worker needs to know about each topic; nor does the total curriculum claim to be exhaustive. Selections had to be made and limits set to what could be accomplished in this format. What is presented here is the result of the combined experience of the authors as both child care workers and trainers as well as the reactions and expressed needs of child care workers who participated in the training programs upon which the curriculum is based.* These training needs can be grouped in the following areas: self-awareness, human development, assessment and planning, and child care practice. All of these areas are included both explicitly as topics and implicitly as portions or aspects of other topics. The combined effect is a systematic introduction to the major issues connected with each area and how they all interrelate.

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*William B. Limer, Anne Stea, Mary Armstrong, and Wayne Ouderkirk, Child Care Training Needs Assessment (Albany, N.Y.: Continuing Education Program, School of Social Welfare, State University of New York at Albany, 1977).

Self-Awareness. An essential characteristic of the human service professional, self-awareness is required for clarity and perspective on what one is doing and why in working to help others. As a child care worker, one must be sure to answer the needs of the children rather than one's own needs, to use structures and programs that are useful in achieving the goals of placement rather than those that are a reflection of one's own need for control. Obviously not easy to achieve, self-awareness is dealt with in almost every part of the curriculum. First, it is the main topic of two sections: "Self-Awareness: Worker Style," which helps people see how they view their role as child care workers; and "Values, Values Clarification, and the Child Care Worker," which helps workers to perceive the influence of their own values, both personal and professional. Second, self-awareness is a significant component of many of the other modules: "Human Growth and Development," "Loss, Separation, and Placement," "Children, Families, and Child Care Workers," "Developmental Problems of Adolescence," "Crisis Prevention/Intervention," and "Stress and Burnout."

Human Development. It is practically self-evident that a child care worker needs to know how human beings develop, what problems are particularly difficult at what stage, what unsuccessful development means. The module "Human Growth and Development" is devoted to this set of issues. Although that module is not a substitute for an extended study of human development, it does attempt to connect psychological developmental theory with child care practice. Another module, "Developmental Problems of Adolescence," focuses on teenage growth. Stages of development are important in "Loss, Separation, and Placement," "Child Care Practice," and "Activity Programming."

Assessment and Planning. Child care workers need to know what each child's major problems are and how to go about helping the child deal with them. Assessment of children in residential care requires a great deal of knowledge - of human development, of family dysfunction, of losses experienced by the individual; each of these has a module devoted to it. The process of goal planning is explicitly treated in "Child Care Practice," program planning in "Activity Programming." Still other facets of assessment make up portions of "Building Therapeutic Groups," "Developmental Problems of Adolescence," and "Crisis Prevention/Intervention."

Child Care Practice. This is really the whole of which the previous subjects are parts. It is, quite simply, what child care workers do when they are working with children, what they do in order to achieve the goal set in accordance with the assessments. "Child Care Practice" includes detailed training sections on two specific child care techniques. "Building Therapeutic Groups" is a high priority in child care practice, as is "Activity Programming." "Crisis Prevention/Intervention" is, perhaps, the culmination of child care practice. If done correctly, it requires all the knowledge and skills of the other modules focused on the child in a crisis situation.

It should be obvious that no one of these content areas is completely treated in the curriculum. But it should also be obvious that the training sessions included herein provide a strong starting point for the child care worker.

TRAINING*

Training is not identical with education, though the two are intimately related. A rough and ready characterization of the difference is that, while education is traditionally concerned with imparting knowledge, training is concerned with imparting not only knowledge, but also skills and attitudes. Of course, when closely examined, it turns out that traditional education is also in the business of imparting skills and attitudes. Actually, the main difference in this regard is that education has usually claimed explicitly to be concerned only with knowledge; training, a relative newcomer to the learning scene, devotes explicit attention to skills and attitudes as well. The reasons for such attention to skills and attitudes should be clear. A great deal of knowledge about a subject area guarantees neither the ability to apply and adapt that knowledge to the problems at hand nor the appropriateness of attitude requisite for such application. Of course, there need not be such a difference - education could easily devote more explicit attention to skills and attitudes (indeed, such a change seems to be coming about in our colleges and universities).

This thought, however, points to further differences between traditional education and training. First, as a means of providing learning experiences for adults, training explicitly recognizes that the student already has a great deal of knowledge gleaned from life experiences; it seeks to elicit an awareness of that knowledge and to make it useful to the individual's present situation. Second, as a result of this recognition, training looks different, is structured differently from a traditional educational experience. For the traditional teacher-student (speaker-listener) structure, the format of training substitutes the trainer-participant (facilitator-learner) interaction.

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*The word "training" has some negative connotations that conjure up images of mere mechanical abilities without any human content. Perhaps a better title would be "adult education," and the reader who dislikes the term "training" is encouraged to substitute this term wherever necessary.

That role difference is important and is reflected in this curriculum. The trainer's job throughout is to provide situations in which the participants can learn about their already existing knowledge, their new information, their attitudes, and their skills. As a result there is only a small proportion of time devoted to traditional lectures. In the majority of the training exercises, the participants are asked to do something - role play, work in groups on assigned tasks, complete individual exercises, or discuss issues. The basic assumption in all of this is that participants, as adults, are responsible for their learning; the trainer cannot make them learn. Indeed, adults usually resent someone who tries to make them learn.

To many, the activities included in a training session look like gimmicks rather than learning experiences. They are intended to be as enjoyable as possible; but they are, nevertheless, learning experiences. Designed to make people think, to use knowledge, to organize, to expose assumptions, the exercises are strongly committed to the belief that, if you ask an interested person the right question, he or she will come up with the right answer. In order to use this training curriculum well, the trainer must accept this format and its assumptions. It involves a recognition, on the part of the trainer, of the participants' abilities and interest. Those who have learned to use this kind of format have found that it works.*

THE USE OF THE CURRICULUM

All sorts of possibilities exist for the use of this curriculum: collaborative efforts among different agencies or team training within agencies by persons with different interests and expertise; the use of the whole curriculum as a training course or the use of selected modules based on need and interest; or combinations of these. It should be clear, then, that we do not offer this document as a rigid manual of directives. Rather, we see it as flexible and adaptable enough for many different purposes. No matter how it is used, however, those who use it need to know the function of its design.

The training process must, like the practice of child care itself, include some sort of assessment. If the training is to be as effective as possible, the trainer must know the levels of knowledge and skills, and the kinds of attitudes possessed by participants. One purpose of the "Case Example for Assessment and Evaluation of Training," immediately following this introduction, is to help the trainer obtain a somewhat objective measure of those levels and attitudes. A second purpose of the example is evaluative - to help the trainer determine the effectiveness of the training. Both these purposes bear commenting upon.

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*For more information and discussion of training, see Robert Mager, Preparing Instructional Objectives (Belmont, Calif.: Fearon Publishers, 1975) and Larry Nolan Davis and Earl McCallon, Planning, Conducting, and Evaluating Workshops (Austin, Tex.: Learning Concepts, 1974). For a discussion of some specific issues of child care worker training, see Wayne Ouderkirk and Jerome Beker, "Opinion Exchange: Education and Training for Child Care Workers," Child Care Quarterly 9, no. 3 (fall 1980).

As presented, the example is a means of finding out how much someone knows about the content of the curriculum. Knowing a lot about that content does not, of course, make someone a good child care worker. But how much one knows is an objective measure of how much this curriculum could help in improving that person's practice. The trainer can and should use this information in several ways.

First, after administering the case example as a pretest, the trainer can use the results to determine the level of sophistication of the training. This way of using the assessment case is particularly useful where a group of workers must, because of administrative policy or whatever, go through a specified amount of training. If they are experienced workers, the trainer can gear the sessions to that level; if not, he or she can simplify the sessions. Second, the trainer can use the example to eliminate time wasting sessions. Perhaps the workers have already had training on one or more topics. Unless a review is desired, those sessions could be omitted from a projected course of training. In addition, the same can be done for individual workers who might have a special interest in one or more topics. If they cannot serve as trainers themselves, at least they can avoid the boredom of repetition.

There are good ways and bad ways of using the material as a pretest. The people who produced the curriculum hope the pretest will help workers to see what they need to know. We strongly discourage its use as any sort of job-performance evaluation or device for screening job applicants. Used as either of those, it will serve neither agency nor children.

Evaluation, the second use of the case example, is to be seen as a method of criticizing the training, not as the grading of participants. If participants show no change between pretest and post-test (using the same case and questions), training has not been effective and needs reworking. Using the measures provided by the pretest and post-test and other participant feedback, the trainer can usually pinpoint the problems connected with individual training activities. Also, in time, the modules will have to be reworked, based on changes in the practice of child care. The evaluative use of the case example will assist in both these processes.

In addition to the case example, a self-assessment form is included with the handouts for each module. Its main purpose is to encourage the participants to monitor their own performance after training. They can note, in connection with a given action, how often they do it; they can be reminded to note it again at three-month and six-month intervals. In this way they can determine for themselves how well they are utilizing training and how useful it was for them. The trainer can also request to see such sheets (without the owners' names) to help determine whether training is continuing to have salutary effects.

THE MODULES: SECTION BY SECTION

Each part of the modules has a purpose, and the following is a description of those parts and purposes:

Introductions introduce. Some give a bit of the background of the module at hand, but all give the module's purpose or rationale. Neither capsule description nor content summary, the introduction gives only the reasons why its topic is important in child care.

Behavioral Objectives and Behavioral Changes state what the worker should be able to do after participating in that training session and how that new-found ability will be evident in the worker's behavior. These objectives and changes also include attitudinal changes connected with the behaviors and skills. In all cases, the modules state these changes modestly. Perhaps other changes will also occur.

The behavioral objectives and changes are closely tied to the training session provided in each module. If a trainer wishes to achieve other or additional objectives, it is important that the training activities be appropriate to achieving the new objective. If they are not, new activities must be used. Similarly, if one or more activity is omitted from the session, the trainer must remember that one or more objectives may not be achieved. It is not claimed that the activities given are the only ways of achieving the behavioral objectives. We encourage trainers to use their imagination and creativity to improve upon the sessions, as long as they keep in mind the connection between the behavioral objectives and session activities.

Resource Papers may be used in several ways. Their purpose is to present the content of the module in written form so the trainer can use it in preparing for the training session. These papers vary in scope and length, but all of them provide information about the subject of the module and give the sources of that information. The paper may be used as an introduction or a review, depending upon the trainer's familiarity with the subject. It may also serve as a reference for in-depth reading. In sessions that include a lecture presentation, the resource paper forms the basis of the lecture's content. No other limit is placed on those lectures; each presenter will have a personal and unique style, and we encourage that uniqueness. In preparing such lectures, trainers will find it helpful to refer to the works listed in the resource paper and annotated bibliography. A word of caution is appropriate, however: the resource papers are not written as model lectures to be presented verbatim to participants. Their design makes them inadequate for such use, and such use would be contrary to the spirit in which this whole curriculum is offered.

Session Outlines contain, in as much detail as possible, specific instructions on how to deliver a training session on each topic. Uniting the purposes, behavioral objectives, and content from the resource papers, the training sessions are the core of the curriculum. They include a list of logistical requirements - time, space, equipment, handouts, and other materials needed - and a description of a proposed training session from introductory comments to summary.

The highly important link between the activities in the training session and the behavioral objectives was discussed above. So was the possibility of altering the sessions, but more needs to be said in that regard. Each of the sessions given in the curriculum is the result of a long period of use in training child care workers. During that period, we, the authors, designed and redesigned the sessions based on the reactions and evaluations of participating child care workers and on our own developing sense of what is effective and useful. In other words, we went through a lengthy training ourselves before publishing these sessions for others' use. It is our suggestion, then, that trainers (especially new trainers) try out the sessions as presented here before changing them. After getting the feel of the sessions as they actually work, the individual trainer can better tailor them to his or her own style and needs.

One item in the session descriptions, time, needs further comment. In two senses, there is never enough time for training. First, we all know that training in residential child caring agencies is often squeezed in here and there. By now, however, it should be obvious to everyone how crucial and helpful training for child care workers actually is. So, it is our view that time needs to be provided to present a thorough training program. Haphazard, quickie training sessions do more harm than good. The second sense in which there is never enough time for training is that training sessions usually exceed their time limits. Generous allotments have been made for all the training activities of each session, but the trainer will probably still find things a bit tight at the end. One tip that may help is to learn to cut off discussions after major points have been made but while the participants are still interested. That way participants will be more likely to discuss these topics outside of training, and the trainer will be less likely to have to cut out activities.

The training materials listed in each session outline include several types of items. Each module has a self-assessment form for participants to monitor their own progress in using the training. Many modules contain materials for the use of the trainer. Some of these are appropriate as handouts, some not (e.g., fantasy trips). Exercise sheets are also included. All are reproducible for training purposes.

Annotated Bibliographies at the end of the modules are intended as an initial guide to the literature related to the modules. Some references are repeated in different modules so that the modules can be used separately or by trainers in the same program.

These comments should prove helpful as an introduction to the curriculum. To become adept at using the curriculum, however, the trainer will need to jump in and to get immersed in the modules, one at a time, to see how they are put to use, how they feel, and what they do. We are confident that the curriculum is a useful resource; we hope it will be used in the spirit in which it is offered.

CASE EXAMPLE FOR ASSESSMENT AND EVALUATION OF TRAINING

The following case example is meant to be administered as a test to curriculum participants before and after they take part in the curriculum. The pretest results will serve as a measure of how much the participants already know about the content of the curriculum. The trainer can use this information to determine the desired level of the training and to eliminate topics with which participants are already familiar.

The post-test results are a measure of the effectiveness of the training and can be used to improve future training. A more detailed discussion of the use of the case example for assessment and evaluation is given in the Introduction to this curriculum.

RAY Q - A CASE EXAMPLE*

Ray Q.: Reason for Placement

Ray was arrested by Colonie police on April 4 for shoplifting at Sears, Roebuck. At about the same time, his junior high school principal was filing a petition for Ray's truancy with Albany County Family Court to have him declared a person in need of supervision (PINS). The court subsequently ordered an 18-month placement for Ray at a residential treatment center for adolescent boys.

Family Background (summary)

Mother: Rebecca, age 30
Father: Ray, Sr., age 32
(present address unknown)

Children: Beckie, age 14
Ray, age 13
Neal, age 9
David, age 7
Patti, age 2

Ray's parents were married while still in high school. When they found that Rebecca was pregnant with their first child (Beckie), both quit high school and Ray, Sr., took a job as an unskilled laborer. For a short time they lived with Rebecca's mother, but moved out because of conflicts with her. When Ray, Jr., was one year old, his parents went to California to visit Ray, Sr.'s, brother. They left the children with their maternal grandmother, but did not return for a year.

After their return, the marriage got progressively worse. Rebecca says she continued to have children to keep the marriage together. She describes the marriage as unhappy and now says that she hates Ray, Sr., because of his drinking and inability to take care of their family. He abandoned them when she was pregnant with their fourth child. At that time she put the other three children into a foster home for a year. The youngest child (Patti) is the offspring of a common-law relationship; the man also abandoned the family.

Rebecca reports that her mother helps her with the younger children but constantly criticizes her, "Just like when I was growing up."

Rebecca says that Ray, Jr., was a slow-developing child and didn't walk or talk until late, although she recalls him walking and talking a bit when she left for California. He was difficult to feed and slept poorly; he was a temperamental, resistant child from the beginning. For example, she says he was unhelpful and undependable and couldn't dress himself and make his bed till he was six years old. Because of these difficulties she often had her mother take care of Ray. She says his undependable nature is just like his father's. As an example she points out that Ray has always misbehaved whenever his father has left, probably because "he wanted to run away just like his father."

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*This case example may appear to closely resemble the experiences of many children and families involved in residential care. However, the case is fictional.

Ray

Ray is a bit bigger than the average thirteen-year-old. Behaviorally, he also comes across as older than thirteen, projecting a tough, independent front; he says he can take care of himself. In school, when he was there, he was unable to get along with his peers, constantly running them down and teasing. At the same time, say his teachers, he reacted violently to others' teasing him. He did not form any strong relationships with other children or teachers, and told teachers that he didn't need their help. He was impulsive and demanded instant gratification.

Placement History

One month ago, Ray was placed in a group living unit consisting of eleven other young adolescents at a home that has a total capacity of sixty boys and is located in a different area of Ray's hometown. All the boys at the home are on JD (juvenile delinquency) or PINS placements. The program is a highly structured one, but the agency is not a secure detention (lock-up) facility.

Child care workers have been carefully observing Ray to develop appropriate goals. They have found two conflicting sets of behaviors in Ray. On the one hand Ray has a tough "older-than-thirteen" exterior. This was evident in the first week and a half of his placement, when he projected a "together-loner" image of himself. He told the other boys he was there because of "family problems," and that the shoplifting charge was "no big deal." ("I could have beaten that!" Ray said.)

To the staff, he was responsible to the letter, not the spirit, of the house rules. "Just tell me what I gotta do, man; I can take care of it," Ray declared. To him, the rules were too strict, but he said he would follow them as long as "these kids" didn't bother him. He was true to his word for a while.

Ray continued to try to maintain this facade, but his other set of behaviors often became evident, too. In group situations, he has been silly to the point that other boys have called him a little kid. Ray has reacted to this with anger. On two occasions in the last two weeks he has been in fights because of the others' teasing him.

Another fight occurred as he was participating in his first group game, a pick-up game of basketball, after two child care workers had spent a lot of time talking him into playing.

It was obvious to the workers that Ray was unable to live up to his bragging about his athletic prowess, and that he started the fight when his opponents were insulting his ability, though Ray claims he was "tired of getting fouled." In these episodes, as well as other situations, Ray "loses his cool" and reacts in a childish, immature way. In arts and crafts, for example, he has begun several projects, but destroyed them before completion. At the table he often grabs food before it is passed around to him, and the staff has found that he hoards food in his locker.

Some other observed behaviors reported by child care workers are: crying himself to sleep (on several occasions), leaving school (almost daily), running away (to his home, once), refusing to participate in group activities, and "bad mouthing" the staff.

In his relationships with people, Ray seems limited. He has no friends among the boys in the unit and has not developed a relationship with any of the child care workers. He says he doesn't care to see anybody from his old school because he "didn't have any friends there anyway."

On the two Sundays when his mother, Rebecca, came to visit him, he didn't relate very well to her, either. He was warm and animated toward his younger siblings, including the toddler, Patti, on the one occasion they visited with Rebecca. Staff reported that Ray ignored his mother's directions when he was getting too rough with his brother David, age seven. They also said that several of her directions, after Ray had ignored her, included various threats, both physical and emotional ("I'll leave you in this place if you don't leave your brother alone," she told him.) On the second visiting day, when she was trying to leave, Ray wouldn't respond to her call (they were by the playground). One of the child care workers volunteered to help and got Ray to come over and say goodbye.

Besides running away and fighting, Ray has been involved in one additional crisis in the month he has been placed. Last Friday, after school, he was about to get into a fight with Willie, who was going home for the weekend. Bob, the child care worker who entered Ray's room when the fight was about to start, put his arm in front of Ray to stop him from attacking Willie. Before Bob knew it, Ray said "Stay out of this!" and punched him. With the help of one of the other child care workers, Bob restrained Ray, who struggled, swore, threatened, and spat for forty-five minutes. Ray then fell asleep, exhausted. Later in the evening, Ray refused to talk about it. Willie claimed that Ray started it but admits that before Bob arrived he had argued with Ray about going home.

The following questions and statements are related to the case example you have just read. Choose the response that best answers or completes each item.

1. Which major developmental issue is Ray Q. struggling with?

   a) identity versus role-diffusion
   b) trust versus mistrust
   c) both of these
   d) neither of these

2. Based on his behaviors, what stages in the grieving process is Ray going through?

   a) detachment and despair
   b) preprotest and protest
   c) protest and despair
   d) denial and detachment

3. Would you say Rebecca's description of Ray's infancy reveals

   a) about the right development
   b) as Rebecca says, "slow developing"
   c) slightly advanced development

4. For Ray's behavior, would you say Rebecca has

   a) age-appropriate expectations
   b) lower than age-appropriate expectations
   c) higher than age-appropriate expectations

5. Ray's tough, independent image is a common characteristic of children whose parents

   a) were always very strict with the child
   b) probably never wanted the child in the first place
   c) never had their own needs met as a child
   d) rarely let the child play with others

6. Based on what you know, Rebecca seems to need help, wnich the child care workers can give her, on

   a) visiting procedures
   b) how to set limits
   c) role identity
   d) expressing her repressed anger

7. Most WAR (World of Abnormal Rearing) cycle families exhibit

   a) poor social perception
   b) social apathy
   c) social isolation
   d) poverty

8. One worker has said of Ray's fighting: "That's a value he has from his life on the street, and it's wrong for me to try to put any values on him." This worker is saying, by implication:

   a) Kohlberg's theory of moral development is right
   b) Kohlberg's theory of moral development is wrong
   c) nothing about Kohlberg's theory
   d) some of Kohlberg's theory is right, but the rest doesn't fit

9. A major developmental issue for Ray, as an early adolescent, is

   a) group identity versus alienation
   b) personal identity versus diffusion
   c) autonomy versus shame and doubt
   d) industry versus inferiority

10. Major theories about loss and separation have been worked out by

   a) Bowlby, Erikson, and Kohlberg
   b) Erikson, Thomas, and Kubler-Ross
   c) Kubler-Ross, Lindemann, and Erikson
   d) Lindemann, Kubler-Ross, and Bowlby

11. Developmental psychologists tell us that movement or growth occurs only when the

   a) person experiences disequilibrium
   b) person experiences equilibrium
   c) person has consolidated gains
   d) present stage is completely mastered

12. According to Erikson's theory of human development, the positive resolutions of the early stages can be described, in order, as

   a) trust, initiative, autonomy
   b) trust, autonomy, initiative
   c) initiative, autonomy, trust
   d) autonomy, initiative, trust

13. All of the following are possible uses of activity programs in child care. Which of them is the most professional child care use of activities?

 a) evaluate achievements of goals
 b) help children develop forms of self-expression
 c) give children exercise
 d) keep the children occupied

14. Three components of activity analysis are

 a) child care worker tasks, social worker tasks, psychiatric tasks
 b) body motion, amount of competition and interaction, degree of structure
 c) degree of structure, number of roles, role of adult
 d) large motor activity, small motor activity, eye-hand coordination

15. Because of his early experiences, Ray Q. probably never gained

 a) a sense of trust
 b) a sense of autonomy
 c) both of these
 d) neither of these

16. In terms of early developmental tasks, Ray experienced many difficulties. Because he is now a teenager, child care workers need to

 a) help him work on adolescent developmental problems, since the other problems are long forgotten
 b) help him work on the early developmental tasks, and ignore the adolescent developmental issues
 c) empathize about his early problems but stress his present competencies
 d) do none of these because they are inappropriate child care responses

17. Objectively speaking, we could say that Rebecca (Ray's mother) has inadequate parenting skills. This is because

 a) she is a lousy mother
 b) she doesn't love her children
 c) she has not bothered to learn to parent
 d) no one ever taught her how to parent

18. In setting up goals for Ray Q., the best short range goal among the following, as defined by Administrative Letter 100, is:

a) Ray will stop being physically aggressive as a means of expressing his anger
b) within three months Ray will stop being physically aggressive as a means of expressing his anger
c) within three months Ray will leave the scene of a difficulty rather than fighting unnecessarily
d) within three months Ray will be able to talk about any fights he gets into and will be able to accept the child care worker's intervention

19. Considering only Ray's need for relationships, the worker style best suited to that need would be

a) credibility (9/9)
b) client-centered (1/9)
c) charismatic (5/5)
d) custodial (1/1)

20. Which of the following can be a role function of the child care worker in relation to the parents of children in placement?

a) assessing family structure
b) modeling appropriate expression of feelings
c) showing parents their errors
d) none of these

21. In order for the child care team to develop the unit (living group) of children into a cohesive therapeutic group, it is essential for them to

a) be aware of their dynamics as a group
b) be involved in group therapy
c) involve the children in all decisions affecting the group
d) be sure all incoming children will complement the existing group

22. An entry in the child care log in Ray's living group says: "Ray continues to be a loner, both behaviorally (he spends a lot of time by himself away from the group) and verbally (he tells everyone he doesn't need any help)." This is an example of the child care worker exercising which function in working with the group?

a) provider of safety
b) observer/communicator
c) provider of relationships
d) assessment for planning
e) all of these

23. Which of the following is not one of the steps involved in life-space interviewing?

a) listening to child's view of what happened
b) exploring alternative views of what happened
c) getting child to take responsibility for his actions
d) developing alternative behaviors for child's self-expression

24. Which of the following is not one of the reasons why children in placement have difficulty forming therapeutic groups?

a) psychosocially they have not developed beyond latency age
b) they have not achieved the level of abstract thinking
c) they are unable to give up a certain amount of autonomy
d) they do not want to risk losses

25. Initial activity programming for Ray should stress activities that

a) have a lot of interaction among participants
b) have little interaction among participants
c) have a lot of structure, rules, etc.

26. The number of developmental tasks that Ray faces just in adolescence is:

a) one
b) two
c) three
d) four

27. In professional child care practice

a) personal values don't enter at all
b) personal values shouldn't enter but sometimes do
c) personal values should be replaced by professional values
d) personal and professional values interact

28. If we wished to use the technique called "teaching alternative behaviors" with Ray, we would first want to

a) describe the negative behavior
b) stop the negative behavior
c) tell Ray what he's doing wrong
d) contract with Ray about what needs changing

29. The statement that best describes Jay Hall's 9/9 or "credibility" worker style is:

a) one person can't really change another
b) man has the inner ability to change but is overwhelmed by his environment
c) man is motivated by rewards and punishment
d) behavior is learned and therefore must be changed through relearning

30. The best long term goal for Ray is:

a) Ray will stop resorting to physical aggression to solve his problems
b) by the end of his placement (eighteen months), Ray will be able to deal with problems appropriately
c) by the end of his placement (eighteen months), Ray will be able either to leave the scene of a difficulty or to talk with the other person, rather than fighting unnecessarily
d) when he returns home, Ray will be able to control his temper

31. In attempting to reduce Ray's fighting, the child care worker has to arrive at a full description of that behavior. Which of the following is not a part of describing that behavior?

a) coping mechanisms
b) mode and pace
c) frequency and location
d) activity dimensions

32. In working with a group of children from various cultures, the child care worker's goal is to achieve

a) a "cultural democracy"
b) a "cultural melting pot"
c) a single cultural orientation
d) none of these - culture doesn't enter at all

33. In a crisis situation, the professional child care worker

a) acknowledges his or her own feelings and reacts appropriately to them
b) acknowledges his or her own feelings and brings them to the attention of the child
c) ignores his or her own feelings and focuses on those of the child
d) is cool and calm because the crisis has nothing to do with him or her

34. In child care work all crises are

a) preventable and hence avoidable
b) not preventable and hence not avoidable
c) not preventable but not helpful
d) not preventable but helpful

35. Activity analysis relates to

a) planning effective child care schedules
b) coordinating placement goals and recreation programs
c) coordinating social worker and child care worker efforts
d) developing accurate child care job descriptions

36. Which of the following is not a part of the child care worker's role in building therapeutic groups?

a) provider of safety
b) provider of corrective experiences and hope
c) observer-communicator
d) goal planner

37. The process of valuing consists of

a) prizing, choosing, and acting on
b) choosing and acting on
c) prizing and acting on
d) believing, prizing, and acting on

38. If a child worker establishes a positive relationship with Ray and Ray accepts direction only from that worker, which change-agent style should the worker begin to emphasize?

a) either custodial or compliance
b) either compliance or client-centered
c) either client-centered or credibility
d) either credibility or charismatic

39. Which behavior of Ray's indicates that he may be in the pre-protest or denial stage of the grieving process?

a) following the rules (honeymooning)
b) breaking the rules
c) hitting the child care worker
d) none of these

40. The major theories of loss and separation

a) are very different in their interpretations of grief behavior
b) are identical in their interpretations of grief behavior
c) are only slightly different in their interpretations of grief behavior
d) examine different aspects of grief behavior

41. In crisis situations, the child care worker must be able to

a) use a variety of intervention techniques
b) use a single intervention technique
c) prevent outbursts of acting-out behavior
d) use a life-space interview to defuse the situation

42. Clinicalism is the belief that

a) all individuals have psychological damage
b) clinical assessment must include ethnic factors
c) individuals have psychological damage as the result of the treatment of the individual's race
d) racial/ethnic factors are irrelevant to clinical issues

43. The general category of behavior that might actually be a manifestation of cultural difference rather than of inappropriate behavior is

a) inadequate communication skills
b) socially unacceptable behaviors
c) lack of response to conventional approaches
d) all of the above
e) none of the above

44. In a group of children in residential care, it is clear that the workers are doing their job in terms of forming the children into a cohesive group when it can be seen that among the children

a) the group has no dominant leaders
b) the group has one dominant leader
c) the group leaders direct the other members
d) the group leaders assist the other members

45. The client-centered (1/9) worker probably believes

a) man is motivated by rewards or punishment
b) man needs leadership and a sense of belonging
c) behavior is learned, and must be changed through relearning
d) one person can't really change another
e) none of these

46. In child care, the workers' change agent styles

a) can be consciously manipulated by team decision
b) must be fixed and consistent
c) need to be all of the same type
d) must stress the importance of commitment

47. When Ray punched the child care worker, the stage of the crisis in which the worker intervened was

a) beginning stage
b) middle stage
c) final stage
d) none of these

48. If the worker had been able to assess the situation properly, which factor would have given him a cue to focus on in preventing the situation?

a) Willie was going on a home visit
b) Ray gave no cues in this situation
c) Ray and Willie often fight
d) the school reports from that day

49. One of the child care workers who works with Ray is attempting to get Ray to stop grabbing food at the table. To do that correctly, it is crucial for the worker to

a) be firm in telling Ray to stop doing it
b) be clear about why Ray is doing it
c) be ready to offer Ray substitute behavior for the same situation
d) role model the appropriate behavior

50. To get Ray to stop bragging unrealistically, to stop silliness, etc., the child care worker needs to help Ray find another way to gain peer acceptance. The most important characteristics of this new behavior are that it be both

a) age appropriate and able to show Ray's skills
b) able to show Ray's skills and able to accomplish treatment goals
c) able to accomplish treatment goals and something Ray likes to do
d) age appropriate and able to diminish self-defeating behavior

51. In terms of children experiencing grief because of losses associated with residential placement, the child care worker

a) has simply to respond to the children's expressions of grief
b) has work to do in helping the children begin the early stages of grief
c) has work to do in helping the children experience the later stage of grief
d) has work to do in helping the children experience the whole grieving process

52. Many systems of values "intersect" in child care worker practices. Which of the following systems contains values about which the child care worker must be aware?

a) the clients' beliefs - i.e., the beliefs of the child and family
b) the agency's purposes and goals
c) the psychological model used at the agency
d) all of these
e) none of these

53. In using the life-space interview, the worker must concentrate on

a) making his verbal message clear
b) making his nonverbal messages fit his verbal messages
c) neither a nor b; the focus is on the child
d) both a and b

54. In using the life-space interview technique with Ray after his fight with Willie, a worker would be most interested in

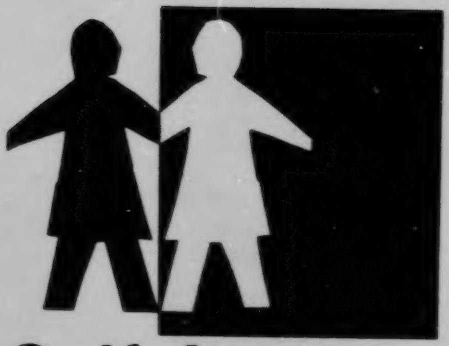
a) hearing Ray's view of what happened
b) stressing the seriousness of what Ray had done
c) conveying the worker's perception of the situation
d) none of these

Answer Key

1. C
2. B
3. A
4. C
5. C
6. B
7. C
8. B
9. A
10. D
11. A
12. B
13. B
14. B
15. C
16. D
17. D
18. D
19. C
20. B
21. A
22. B
23. C
24. B
25. B
26. D
27. D
28. A
29. D
30. C
31. D
32. A
33. A
34. D
35. B
36. D
37. A
38. C
39. A
40. C
41. A
42. C
43. D
44. D
45. E
46. A
47. B
48. A
49. C
50. D
51. D
52. D
53. D
54. A

The following list correlates each module with the questions that serve as direct test items for it. Since some disagreement could arise about some of the given answers, a review of the material in the specified module should help clear up any such problems.

Module	Question Numbers
Self-Awareness: Worker Style	19, 29, 38, 45, 46
Values, Values Clarification, and the Child Care Worker	27, 37, 52
Human Growth and Development	1, 3, 11, 12, 15
Loss, Separation, and Placement	2, 10, 39, 40, 51
Children, Families, and Child Care Workers	3, 4, 5, 6, 7, 17, 20
Child Care Practice	
Section I: Goal Planning	18, 30, 31
Section II: Teaching Alternative Behaviors	28, 49, 50
Section III: Life-Space Interviewing	23, 53, 54
Building Therapeutic Groups	21, 22, 24, 36, 44
Activity Programming	13, 14, 25, 35
Developmental Problems of Adolescence	8, 9, 11, 16, 26
Child Care and Cultural Differences	32, 42, 43
Crisis Prevention/Intervention	33, 34, 41, 47, 48



Self-Awareness: Worker Style

by Anne Stea

INTRODUCTION

As a member of a therapeutic team, the child care worker daily plans, assesses, and implements strategies for helping children make important changes. Each time a worker develops a specific treatment goal, helps a child through a particular daily routine, or praises a child's accomplishment, he or she is helping that child make behavioral and attitudinal changes. Because the role of agent of change is so basic to child care, it becomes very important for each worker to take a look at his or her own style of implementing change.

In any team of child care workers, there will be as many unique working styles as there are team members. This built-in diversity can be advantageous if the strengths and weaknesses of each worker are used in complementary ways. However, if the individual workers have never taken the time to consider both the strengths and weaknesses of their own change style and how to use each other more effectively, the diversity of styles may cause ambiguity, inconsistency, and insecurity for the children in care.

One purpose of this module is to become aware of how a person's own attitudes, values, and experiences affect his or her working style. A second purpose is to provide a method for exploring and discussing different situations, issues, and types of children for which each basic worker style is best suited.

Finally, all modules seek to increase each worker's awareness of how his or her style complements those of fellow team members. This enhances the team's ability to work with maximum effectiveness.

BEHAVIORAL OBJECTIVES

At the end of this session, participants will be able to

1. Define each of the five change agent styles presented. The definition will include the philosophy, strategy, and evaluation technique of each style.
2. Tell which of the styles is the primary and which the secondary style that he or she uses on the job.
3. List at least one situation for which each style is most effective.

BEHAVIORAL CHANGES

1. A worker seeking help in dealing with a particular child or incident will know which team member's style is most appropriate to the situation.

2. The team will be able to reduce the frustration of each member by reassigning tasks based on the strengths of each person's style and by matching children with workers.

3. The worker will learn new ways to handle certain types of children or situations by observing the different styles of other workers.

4. Workers will be more flexible and more comfortable in a variety of situations because of their knowledge of different styles.

RESOURCE PAPER: THE WORKER AS AN AGENT OF CHANGE

Whenever there is an attempt to list the necessary skills of child care, inevitably such things as assessment, development of treatment goals and plans, and therapeutic use of group and program are mentioned. The list of skills designates the child care worker as one who helps children to look at their behavior (both strengths and weaknesses) and to set goals that will enable the child to make appropriate behavioral and attitudinal changes. In essence, child care work is planning for and enabling change.

As agents of change, child care workers must ask themselves several questions. Can changes really be made? If so, how and by what means are changes being measured? Obviously, the worker's own values and emotional, psychosocial, and cognitive development, as well as the cultural and situational environment, will affect the worker's attitude about whether he or she really can change someone else, and if so, what method will work best. All of these components combine to help formulate each person's working style.

Change Agent Theory and Measurement Instrument

According to the change agent theory of Jay Hall, Martha Williams, and Louis Tomaino, the interaction of three components affects an individual's working style:[1]

Philosophy: Attitudes and value assumptions about how changes are best brought about.

Strategy: What the worker actually does to produce change.

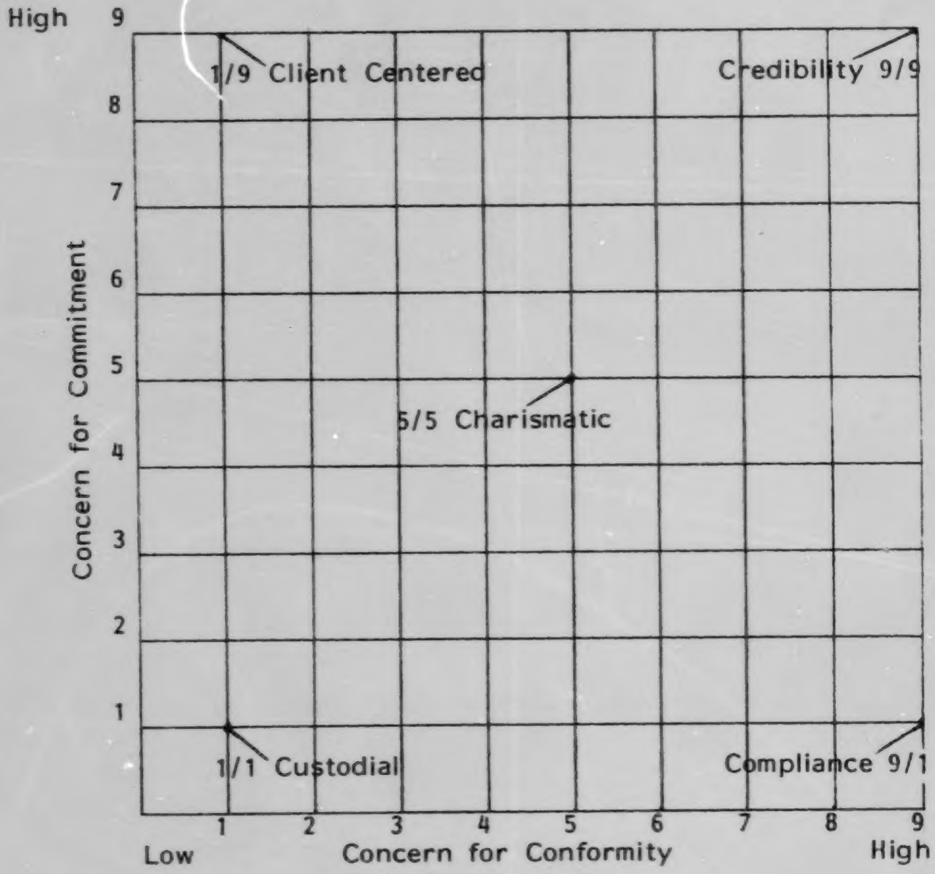
Evaluation: How the individual assesses whether the wanted changes have occurred.

Hall, Williams, and Tamaino also said that each change situation consists of two components:

Conformity: Concern that the changee conform to the change goal, i.e., child stops physical aggression toward teachers; behavioral change.

Commitment: Concern that the changee feels committed to the new standard, i.e., child really feels that he or she does not want to be physically aggressive.[2]

Hall, Williams, and Tomaino used these two components (commitment and conformity) to develop a graph or grid.[3]



Each of the two concerns is represented by an axis on the grid: commitment by the vertical axis, conformity by the horizontal axis. The concerns are measured as being present in any situation in amounts ranging from low to high. Intersecting points on the graph represent integration, separation, or balance of the two types of concern.

Hall has labeled four major working styles that represent the extremes on the two axes and a fifth that represents the midpoint on the grid. Each of these major areas represents some combination of a concern for commitment and conformity. For instance, the worker who scores in the 1/9 area has a maximum concern for commitment and a minimum concern for conformity; that is, this worker wants the child or parent (client) to make changes internally that will then affect his or her outward behavior as well. The 9/1 worker has the opposite concern.

This worker wants behavioral change first of all and does not worry too much about internalization of change.

The worker can find out where he or she fits on the change style grid by filling out and scoring a measurement instrument called the "Change Agent Questionnaire."* This instrument consists of nine multiple-choice statements, divided into three categories. Three of the statements are designed to delineate change philosophy, three strategy of change, and three evaluation of change.

The statements are set up like the following:[4]

1. Change on the part of the changee is more likely to be lasting when

    a. One of several alternative plans is obviously approved by a person whom the changee respects or with whom he is able to identify.

    b. A single course of action has been spelled out and the necessary provisions are made to see that the changee follows that course.

    c. The changee initially has a choice between several alternatives, the feasibility of which he is able to test personally in arriving at his decision.

    d. Both the need for and direction of change are made clear, but the ultimate power of decision to change or not change resides with the changee.

    e. The changee has total freedom from the influence of others in choosing among alternative courses of action, but has support from others once he chooses his course.

The worker reads the first part of the statement and the five ways of concluding it. He or she then selects the answer most characteristic of his or her own style and places the letter identifying that answer nearest the "very characteristic" end of the scale illustrated below. Then he or she picks the least characteristic answer and places its letter nearest the "very uncharacteristic" end of the scale. Letters

Very Characteristic — Very Uncharacteristic

10	9	8	7	6	5	4	3	2	1

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*Teleometrics International has exclusive rights to the "Change Agent Questionnaire." For copies, write to Teleometrics International, P.O. Drawer 1850, Conroe, Texas 77301.

of the three remaining answers are placed above the appropriate numbers between the two extremes. No more than one letter should be placed at any one number.

The instrument also includes a separate score sheet with instructions on how to fill it out. The individual will score higher on one particular column of the score sheet. This high score represents the worker's predominant change style.

The Five Predominant Change Styles

1/1 (Custodial Style)

The worker who exhibits the 1/1 style has a basic philosophy that one person can't really change another, that is, "We are what we are." Based on this philosophy, the 1/1 worker takes a very impersonal approach to change. He or she uses rules, documentation reports, and charts almost exclusively as a strategy. The strategy here is influenced by the "need to do the job" rather than a personal interest in enabling change. Evaluation in this case is based on preset agency standards. This is the worker who feels most comfortable with programs such as token economy, for in this type of program one can concentrate on filling in the earned token charts on a daily basis rather than having to become involved in personal interactions with the child to discuss improvements and difficulties. This worker tends to go strictly by the rules, fills out behavioral charts, posts them on the bulletin board, and basically leaves it to the child to interpret how he or she is doing. Because of a primary interest in following rules and policy and keeping things "as they should be," this style has been labeled the custodial approach.

1/9 (Client Centered Style)

The philosophy underlying this change style is that people have the ability to change but are overwhelmed by their environment. The main concern of the worker with this style is not to become another overwhelming influence. So the approach taken is nonjudgmental and nondirective. The worker plays a supportive role with the burden of change being completely on the child. Evaluation of whether change is occurring is again left up to the child, or possibly the group within which the child is living, but is not done by the worker. For example, if a child asked this worker "How am I doing?" the response would tend to be "How do you think you're doing?" This style is similar to the Rogerian approach in psychotherapy and is labeled the client centered approach.

9/1 (Compliance/Conformity Style)

The 9/1 style is really the opposite of the 1/9 approach. The worker with this style believes that people are motivated by rewards and punishment. Whenever the rewards-punishment principle is involved in change, obviously someone must be rewarding and punishing. The 9/1 worker takes that role comfortably. The strategy involves power, surveillance, and structure. This is the worker who sets up clear behavioral expectations for a child, e.g., "I expect you to go to activities for one week without being involved in any fights or arguments. For every misconduct report you will be restricted from activities for two days. If you make it for a week with no difficulties you will be able to go to the movies with the group on the weekend." Here the worker personally sets up the expectations and consequences. Behavior is evaluated according to these expectations. This worker is much more interested in behavioral change than in the child's commitment to that change. This factor plus the element of power of the worker who takes full responsibility for setting up guidelines and evaluating have combined to create the label compliance/conformity for this change style.

5/5 (Charismatic Style)

A worker of the 5/5 style has the basic belief that people need leadership and a feeling that they belong. Also, this worker feels that people only accept suggestions from those they respect. So he tries to be a leader whom the child will respect; relationship building is the basis of this change style. The worker attempts to get close to the child and then tends to use the approach, "Do it because you love me." Evaluation of change is also based on the worker-child relationship. If in a relationship that appears really solid and positive the child suddenly seems distant, the worker will usually state that all progress is lost. Because of the emphasis that this style places on the worker's prestige, it has been labeled the charismatic approach.

9/9 (Credibility Style)

The basic philosophy of the 9/9 worker is that behavior is learned and therefore must be changed through relearning. The change strategy that accompanies this belief is to create conditions in which the child can learn the consequences of his or her present behavior and explore new behavior in realistic settings. The emphasis here should be on the exploration of new behavior. The 9/9 style worker believes in mutually agreed upon goals. From the very beginning this worker sits down with the child and points out some behaviors that the child probably needs to change, then actively seeks the child's input in the goal planning process. As the child progresses toward mutually agreed upon goals, the evaluation of that progress is once again mutual. This worker tends to involve all people who are important to the child in the goal planning and evaluation processes. The reason for this total involvement by both worker and child is to make the desired change believable for the child, and to help the child be realistic in expectations of himself or herself. It is important to this worker that both external behavior and the related internal feelings change. This emphasis has caused the 9/9 style to be labeled the credibility style.

Interpretation and Application

The 9/9 or credibility worker style is often held up as the ideal for which we in the helping profession should all strive. But many do not support this idea. They feel that any worker must first learn to use his or her own predominant style most effectively. What's more, the timing, type of child, or situation may determine which of the five predominant change styles is most suitable. Following are some examples.

Timing

There are times when 1/1 or custodial style may be best. When a worker is new to the situation it might indeed be best for the supervisor to advise use of this rule oriented approach. For example, when the child asks the new worker, "Why do I have to clean my room?" the best approach for the inexperienced worker might be, "You know what the rules are." This avoids the argument and testing that are so common for the new worker. A consistent use of the custodial approach may be evidence of worker apathy or burnout and should be carefully observed by the supervisor.

Working style is also influenced by timing at other stages of the treatment process. Because of its structure and clear expectations, the 9/1 (compliance-conformity) style is often necessary to help a child who is new to placement feel safe and less anxious. Next, the 5/5 (relationship building) approach may be most effective to give the child a person rather than a structure or rule to hang on to. Finally, as the child nears the time when he or she will be leaving the program, combinations of 1/9 (client centered/supportive) and 9/9 (credibility and mutual decision making) may be most helpful in helping the child learn to make decisions.

Type of Child

The 1/1 style is probably most effective with the very resistant or developmentally retarded child. The constant restating of rules, regulations, and expectations may be the only means by which to begin any work with these children.

The 9/1 or compliance-conformity approach is often most effective with the extremely hyperactive or violent child. Both of these types need the structure and sense of safety within boundaries that a 9/1 style worker will give. The feeling of "control of the situation" is strongest with this working style.

The 5/5 or charismatic style tends to be most effective with the very withdrawn or depressed child. This child needs someone to admire from afar. The child is usually too threatened to react positively to the directive approach of the 9/1 style and not equipped to handle the amount of responsibility required by the totally nondirective 1/9 approach. Given an example of relationship building by a likable, prestigious adult, this child will often seek the beginnings of a relationship.

The 9/9 or credibility style is most effective with the older, more mature adolescent because it allows him or her to become totally involved in decision making and learning from experience.

The 1/9 nondirective, client-centered approach may work best with the child who resents authority. This style would avoid the power struggles and advice giving that are part of the 9/1 and 5/5 styles.

Situation

When a group of children is emotionally high and control is reduced because of contagion, the 9/1 (conformity-compliance) approach is usually necessary to reduce threats and bring back a feeling of control and safety.

With the issue of sexual acting out, the 1/9 (nonjudgmental) approach may be most effective. This style enables the child to do most of the talking without fear of being preached at or made to feel ashamed and guilty.

When a child is being prepared for adoption the 9/9 (credibility) approach is essential. Not only the child but also all involved people (prospective parents, natural family, etc.) must be included in the planning.

Summary

The reader can surely think of many more examples of effective use of specific change styles. The important thing to remember is that no one worker style is most effective. We each tend to be flexible in our use of different styles at different times. As a matter of fact, on completion and scoring of the Change Agent Questionnaire, the individual should take note of his or her second highest score. This is the style that he or she falls back on when the predominant style does not work. For example, when "Johnny, go to your room!" (9/1) doesn't work, the worker with a 5/5 back-up approach may say, "Come on, do it for me."

References (see p. 40 for full listings)

1. Jay Hall, Martha Williams, and Louis Tomaino, "The Challenge of Correctional Change," pp. 493-563.
2. Jay Hall and Martha Williams, *The Change Agent Questionnaire* (Conroe, Tex.: Teleometrics International, 1969).
3. Hall, Williams, and Tomaino.
4. Jay Hall and Martha Williams, *How to Interpret Your Scores from the Change Agent Questionnaire*.

SESSION OUTLINE: WORKER STYLE

Time: Approximately 2 hours, 15 minutes

Space: Room for the whole group and for individuals to work on questionnaires. Participants will need place to write.

Equipment: Easel pad, stand, and markers; or blackboard and chalk; or overhead projector and screen; pencils

Materials: Exhibit - "Change Agent Grid Theory," p. 42
Handouts
    "Self-Assessment: Worker Style," p. 43
    "Change Agent Questionnaire" (with score sheet)*
    "Change Agent Grid Summary," p. 44

Preparatory Note to Trainer: The exercise in this module forces participants to focus on their own attitudes and techniques in regard to changing other people. It is a bit complex, so the trainer must give explicit instructions and be available to help in the completion of forms. The trainer should stress the anonymity of responses and the need to be as honest as possible in completing the exercise. That is, participants should fill out the questionnaire as they know they *would* react, not as they think they *should*.

Care should be taken throughout the session to make the learning nonthreatening by emphasizing that each worker style has its unique strengths, that one style is not necessarily better than another.

1. *Introduction* 10-15 minutes

The trainer distributes the "Self-Assessment: Worker Style" handout and asks participants to respond to the statements by filling in the "before training" boxes. The trainer explains the importance of participants' repeating their self-assessments at three months and six months after training. After the last assessment, they are to return the completed form with their comments to the trainer.

The trainer explains that as child care workers, we are constantly helping children to change both behaviors and attitudes. The child care worker introduces change by establishing treatment goals, helping the child make progress toward these goals, and evaluating the child's attempts to make changes. The child care worker is really an agent of change. A child care worker or any other change agent develops a change style that is based on his or her philosophy, strategies, and evaluations.

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*Teleometrics International has exclusive rights to this questionnaire. See footnote, p. 31

The trainer points out that Jay Hall, Martha Williams, and Louis Tomaino completed a study on worker style. The trainer writes the reference to this study (second item, p. 40) on the flip chart or blackboard. Out of this study, Jay Hall developed an instrument that attempts to measure worker style.

2. Change Agent Questionnaire 30-35 minutes

The trainer distributes the "Change Agent Questionnaire" and explains the process of ranking the five responses to each statement on a scale from "very characteristic" to "very uncharacteristic" (see explanation on pp. 31-32). The trainer should use the flip chart, blackboard, or overhead projector at this time to show an example of how he or she might complete one statement. About 30 minutes are needed to complete the questionnaire.

3. Explanation of Results 25 minutes

After handing out score sheets, the trainer again uses flip chart, blackboard, or overhead to show an example of how to transfer the questionnaire answers onto the separate score sheet. He can use his previous example to show how these answers would be transferred. Participants are told to transfer all answers onto the score sheet and then add up the columns of numbers down the page so that there are five totals, one for each column, across the bottom of the page.

The trainer then explains the results by using a flip chart or overhead of the "Change Agent Grid Theory" and by giving out the "Change Agent Grid Summary" handout. Remember to ask at the end of this presentation if there are any questions, since a lot of material is being disseminated in a short time.

Each column on the score sheet represents one of the five change styles described earlier. At this point the trainer gives the participants the styles as column headings across the page from left to right: 9/9, 5/5, 1/9, 9/1, 1/1. The column in which a participant scores highest indicates his or her predominant worker style.

The trainer then explains some interpretations of the change styles, pointing out that all of them can be used at different times with the same child or with different types of children or situations.

4. Small Group Brainstorming: Worker Styles 20 minutes

At this point the group should be randomly divided into five smaller groups by having participants count off by fives. Each small group is then assigned one of the five worker styles and is asked to brainstorm that style to come up with situations, times, or types of children with which that style is most effective. (For examples, see resource paper.)

5. Processing the Groups

35 minutes

The trainer leads a discussion of the groups' findings, referring to the examples of the styles and to earlier discussions, etc.

Alternate Strategy:

In sections 4 and 5, the trainer could suggest that each small group prepare a short role play of an incident in which its assigned style is most effective. This role play could then be presented to the large group during the processing.

6. Summary

10 minutes

The trainer summarizes the major points of the session, emphasizing that all the styles are useful and important. Participants are then asked to write "I learned" statements about the session; volunteers can share their statements, and the session is over.

ANNOTATED BIBLIOGRAPHY

Bennis, Warren G.; Benne, Kenneth D.; and Chin, Robert, Eds. *The Planning of Change*. New York: Holt, Rinehart and Winston, 1969.

An excellent selection of readings on the principles and strategies of change, including such important issues as resistance. See especially the articles by Benne and Birnbaum (pp. 328-335), Chin and Benne (pp. 32-60), and Watson (pp. 488-498).

Hall, Jay; Williams, Martha; and Tomaino, Louis. "The Challenge of Correctional Change: The Interface of Conformity and Commitment." *The Journal of Criminal Law, Criminology and Police Science* 57 (1966): 493-563.

This article discusses and explains the grid and presents the case that the two factors of conformity and commitment both play a role in change situations like therapy or residential care.

Hall, Jay, and Williams, Martha. *How to Interpret Your Scores from the Change Agent Questionnaire*. Conroe, Tex.: Teleometrics International, 1969.

This manual gives an in-depth explanation of the Change Agent Theory and of each of the five predominant working styles. It also gives statistical interpretations of many patterns that could result from the scoring of the questionnaire.

EXHIBIT AND HANDOUTS

CHANGE AGENT GRID THEORY

(Make one transparency or flip chart sheet for each style)

1/1 Philosophy: one person can't really change another - "We are what we are."
Strategy: rule oriented; a lot of documentation and reporting.
Evaluation technique: evaluation based on agency's preset standards.
Summary description: custodial.

1/9 Philosophy: people have the inner ability to change but are overwhelmed by environment.
Strategy: nonjudgmental, nondirective approach. Minimal surveillance. Burden of change on changee.
Evaluation technique: evaluation left up to the changee or even to the group, but not done by change agent.
Summary Description: client centered.

9/1 Philosophy: people are motivated by rewards or punishment.
Strategy: coercion, surveillance, and structure used. Success depends on power of change agent.
Evaluation technique: change agent imposes behavior standard and evaluates accordingly.
Summary description: compliance/conformity.

5/5 Philosophy: people need leadership and a sense of belonging. They accept suggestions only from those they respect.
Strategy: relationship is used; change agent gains prestige in order to influence.
Evaluation technique: evaluation on basis of how relationship is progressing.
Summary description: charismatic.

9/9 Philosophy: behavior is learned; therefore, must be changed through relearning.
Strategy: change agent creates conditions in which changee can learn. Exploring of present behavior and new behavior in realistic settings; internalization of change.
Evaluation technique: evaluation based on mutually agreed upon goals.
Summary description: credibility (change because you believe in the new behavior as being better).

Based on Jay Hall, Martha Williams, and Louis Tomaino, "The Challenge of Correctional Change: The Interface of Conformity and Commitment," The Journal of Criminal Law, Criminology, and Police Science 57, no. 4 (1966): 493-563.

SELF-ASSESSMENT: WORKER STYLE

This form is for you to use as a measure of what you get out of training; it is also useful for the trainer to evaluate the training. So please be candid in your responses.

Respond to the following three statements by writing "yes" or "no" in the appropriate box of the chart below. Repeat this process at three months and again at six months after training.

a. I have determined my own change agent style.

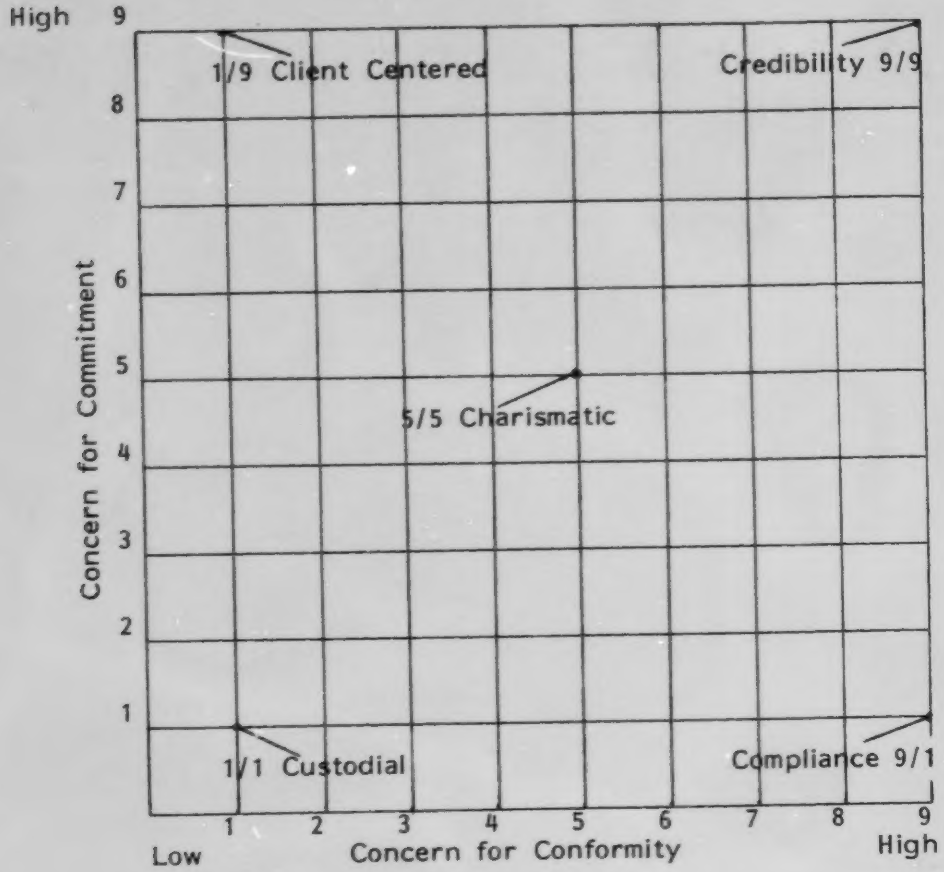
b. My fellow workers and I have determined each of our change agent styles.

c. We have developed strategies to match the worker's style with particular children and situations.

	a. My change agent style	b. Styles of other team members	c. Strategies for matching styles, children, situations
1. Before Training			
2. Three months after training			
3. Six months after training			

Hopefully, the completion of this form will show that you have made efforts to use the knowledge of change agent styles to provide better care for the children you work with. If no change has occurred, try - honestly - to find out why.

CHANGE AGENT GRID SUMMARY*


High
9
8
7
6
5
4
3
2
1
Concern for Commitment
1/9 Client Centered
Credibility 9/9
5/5 Charismatic
1/1 Custodial
Compliance 9/1
1
2
3
4
5
6
7
8
9
Low
Concern for Conformity
High

*Based on Jay Hall, Martha Williams, and Louis Tomaino, "The Challenge of Correctional Change: The Interface of Conformity and Commitment," The Journal of Criminal Law, Criminology, and Police Science 57, no. 4, (1966):493-563. Used by permission.

Change Agent Grid Summary (cont.)

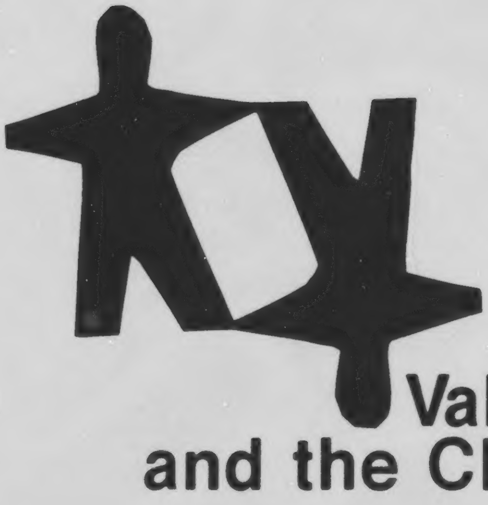
1/1 Custodial change.
One person can't really change another.
Tell changee rules and leave it to him or her whether to follow them or break them and suffer consequences.

1/9 Client centered change.
Change agent must free changee to accept himself or herself.
Nonjudgmental.

9/1 Change through conformity.
Change behavior, not attitudes.
Spell out desired behavior and consequences for failure to conform.

5/5 Charismatic change.
People accept suggestions only from people they respect.
Change agent must gain prestige to influence.

9/9 Since behavior is learned, it is changed through relearning.
Change agent creates condition in which changee can learn consequences of present behavior and explore new behavior in realistic settings.
Change is internalized because it is credible; you believe in it.



Values, Values Clarification and the Child Care Worker

by Wayne Ouderkirk

INTRODUCTION

One of the most consistent responses of child care workers interviewed in 1977 for a curriculum development study concerned their desire for training in self-awareness. A significant aspect of self-awareness is knowledge of our own values and how they affect our decisions and actions. That knowledge becomes even more important for such child care functions as interacting with others, providing therapeutic relationships, and making important recommendations and decisions. It is crucial for professionals to be aware of how their values influence them in such situations.

The purpose of this module is to help child care workers (and other professionals) clarify their values and how these values interrelate. This is the first step in determining how values influence one's behavior. However, since a person's values change and develop as he or she grows, no claim is made that participants will be able to identify all the values that influence their professional decisions.

Of course, values clarification is not the only component of self-awareness. One's style of working, stage of personal development, and attitudes toward grieving and loss are some of the other components of self-awareness that are covered in other places in this curriculum. This module is intended for use in series with those modules, though it can be used separately.

BEHAVIORAL OBJECTIVES

After participating in this session, child care workers will be able to

1. Recognize the importance of values clarification to self-awareness.
2. Identify and explain the three major aspects of valuing.
3. Identify the major sources of values in their lives.
4. Identify their most important personal and professional values.

BEHAVIORAL CHANGES

1. In making professional decisions, workers will try to determine the influence of their personal values on each decision and to weigh the appropriateness of that influence.
2. Workers will discuss values conflicts and issues more frequently with supervisors and fellow child care workers.

RESOURCE PAPER: VALUES AND VALUES CLARIFICATION

There is a myriad of overlapping factors that influence our actions. Often, when such factors are talked about at all, they are lumped into the catch-all category of a person's "background." In attempting to separate these factors and to spotlight their relative strengths in influencing our actions, we must become aware of our value system.

When presented with alternatives of choice and action, our values influence our decisions, both consciously and unconsciously. Naturally, if a political candidate's views coincide with our own views of the way the state or city or country should be run, that factor influences how we vote. If a child is behaving in ways in which a child care worker's own parent had believed children should not behave, that factor can be a strong influence on how that worker acts in that situation. The former situation is a case of values influencing one consciously; the latter is an instance of unconscious influence.

The two examples given provide excellent clues for a working definition of values. Simply put, we can say that values are the way we think things ought to be. The voter believes the country should be run in a certain way, and so does his favorite candidate. The worker (and the worker's parent) believe children should not act in certain ways. These are simple, everyday examples of values.

Values are simple, everyday things. Often when asked what values are, people shy away from answering, mistakenly thinking that values are abstract - difficult to see and pin down. Nothing could be further from the truth. Although there is a lengthy and complex philosophical literature on values, that literature will not concern us here, because it is not normally a part of our everyday values deliberation.

Another reason people shy away from defining values is because of the prevalent view that values are "relative," hence not readily definable. Without launching a detailed philosophical attack on that view, it must be pointed out that in many cases values are not relative. Otherwise, we could not agree as we do about many important issues or join together in common efforts; everyone would do his or her own thing. So, far from being abstract or totally relative, values are everyday aspects of people's lives.

Where do values come from? The most encompassing source of values is our culture. Cultural norms are often the source of important values regarding family structure, performance expectations, and sex roles. Many factors, of course, contribute values within any given culture. Our parents, who are part of the culture, transmit values about child rearing practices and morality. Education shapes everyone's values, which is one reason teachers are important.

The media - television, newspapers, magazines, radio - as well as other forms of entertainment add to the list of values sources. Our peers are still another source. Two other significant influences are religion and profession. And not to overlook the obvious, we also choose and formulate values for ourselves.

Even a cursory look at this list will show that within many of the categories listed still other factors could be singled out. In addition, there are many connections among various categories. So neither is the list complete nor are the categories mutually exclusive. Within such a complex system of influences, potential conflicts easily arise. To take a simple example: as a taxpayer, you may be in favor of reducing taxes; as a professional in child welfare, you may favor more services for children and families - which translates into more taxes. (Of course the two things you may favor, lower taxes and increased funds for children and families in need, are not mutually exclusive. However, given the social and political climate of today, they are mutually exclusive on a practical level.) There are potential conflicts among all influences listed.

Several value systems intersect in the child care field.[1] Conflicts among these systems cause many of the frustrations experienced by child care workers. So it is important that workers become aware of the many real values concealed in their professional transactions. The values of the client are important factors in any interaction. The broader term "client" is used here instead of "child" because child care increasingly recognizes its professional responsibility to the families of the children in care. Whether the worker is in direct contact with the family or not, the values of the family and the child are significant factors influencing the course of residential care.

More specifically, the child and the parents have moral beliefs[2] and other values that govern many of their actions. In speaking of moral values, we have to distinguish two different levels. First, there can be beliefs about what one *should* do in general. It is important to note that these general beliefs may not be, and often are not, explicitly thought out. Secondly, there are particular judgments about particular cases.

These two levels can clash. Problems can arise - real emotional crises, intense reactions - because of conflicts, or what the individual perceives as conflicts, between such general beliefs and specific actions. The teenager who believes in obedience to parents may easily, we can all testify, disobey in various ways. Or the parent who believes in taking care of his or her own children may find it necessary at a particular point to turn over their care to someone else. The point is that clients come to child care workers with values that can easily be in conflict. It is part of the worker's role to be sensitive to such possibilities.

Another possibility for conflicts is between the values of the clients and the worker. In discussions the question sometimes arises as to whether the worker should somehow leave his or her personal values behind in professional functions, since it would be wrong to impose one's values on clients.

While the claim has some initial plausibility, it turns out to be a pseudo-issue. First of all, it is impossible to "leave one's values at home." One's values are part and parcel of one's self. As persons, we child care workers have to maintain our own standards in situations. Second, it is one of the underlying assumptions of this module that such values can influence us unconsciously. That is the reason for clarifying values and their effect on how we act. Third, we child care workers can decide which of two values in conflict will take precedence. By ranking values, we may find that some of our personal values are less important than those of our clients; or that our professional values have to be asserted over our own and our client's personal values. Finally, child care workers have the crucial function of being role models for and teachers of children and parents. Some of the things we wind up teaching are values. *How* we do that is crucially important, since traditional views about it don't work; *that* we do it is a fact of life.[3]

Setting priorities involves the worker's recognition and acceptance of professional values. This, of course, brings in a whole range of issues to be dealt with. Professional ethics[4] regarding methodology and relationships are significant issues that child care workers need to sort out in their various capacities. The value assumptions of psychological theories will function as a partial illustration of this point.[5] Such theories contain a set of assumptions, sometimes explicit, sometimes not, regarding what type of functioning is desirable in a person.

For example, Erikson's developmental theory contains a set of norms, a picture of the ideals toward which the individual should strive. If anyone questions the existence of a normative element in Erikson's theory, it can be pointed out that many professional works - including this one - use his theory as an assessment tool, a standard against which the client can be compared to determine psychosocial stage of development. Child care workers must become aware of the ideal type toward which they are pushing children and families. Such a significant factor needs to be made explicit. In making it explicit in each agency, child care workers will, no doubt, have made a tremendous step toward professionalization.

In addition to the values systems of clients and workers, a third major system of values is inherent in the child care profession - that of the agency or institution. Included here are the agency's stated values and views on children's services as well as unstated values, unwritten rules, and practices. To be effective, the worker needs to know all of these; to be professional, he or she must attempt to bring the unwritten up to the level of the written. An especially crucial value to be conscious of here is the agency's model of child care. Is it custodial or therapeutic? The answer is to be found in the *practice* of child care at that agency rather than in written statements and publications.

A more general system of values affecting the child care profession is that of the child welfare system. Most often, this system is embodied in the local and state social services system. Increasingly, federal agencies also influence the system. Here we have entered the broad political arena, connecting child care practice with a nationwide system. All along the line, the potential for value conflicts is high. Here, too, we return to the conflict mentioned at the beginning of this discussion: the conflict for the person who, as a child care worker, wants more money for services and, as a taxpayer, wants lower taxes. The child care worker must try to resolve such conflicts by clarifying and ranking values in the child welfare and political arenas.

But, like charity, the process of values clarification begins at home. Throughout history and continuing today, people have used various techniques to clarify values. The use of dogmas is one method; it resolves conflicts readily. People mistakenly believe that we use this method less and less; we all still use it much of the time. A 20th century technique, psychotherapy, is another means to clarify values. Clearly, conversations, reading, and thinking are other aids in the process. Anthropologists provide us with data on other cultures, which can be compared with our own culture to clarify our values.

All of these techniques have their merits and demerits. The literature contains plentiful descriptions of group and individual exercises and activities that can be used to clarify values.[6] Examples are used in the training session description of this module. What follows is a brief description of the process to which values clarification theorists subscribe.[7]

Anything that is valued is *prized* in some way. Prizing is a major aspect of the process of *valuing*. It is composed of two elements. One is the individual's emotional, intuitive preference. The second consists of *affirming* that intuitive preference. Whether one is willing to share that preference with others (telling them about it, etc.) is a good test of the strength of that preference, an indicator of pride or lack of pride in the value. That information is crucial for anyone interested in self-growth.

The next major component in the valuing process is *choosing*, which breaks down into three elements. Obviously, if there is to be a choice, one must be able to choose *freely*. The concept of free choice implies *alternatives* to be chosen from. The choice must be made considering *consequences*. Values clarification exercises can help by encouraging the consideration of alternatives.

Finally, the theory claims, with justification, that values are not actually such unless they issue in *action*. In turn, action consists in both *acting* on, doing something about what is valued, and *building patterns* or *habits* of actions. Here values clarification can aid the participants by forcing them to see whether and how often they act on their values.

The use of activities and reflection to examine our process of valuing results in a conscious awareness of what it is we value, how we choose it, and how we act on it. Put differently, the goal is an awareness of beliefs and behavior, an encouragement to consider alternative modes of thinking and acting, and an awareness of the match-up, or lack of it, between what we say we believe and what we do. No professional could want more; and no professional child care worker can work with less.

References (see p. 58 for full listings)

1. The rest of the paper is an adaptation of Ruth Macklin's analysis of the values in the therapeutic situation, as described in "Values in Psychoanalysis and Psychotherapy," pp. 133-150. The only additions to her fine account are the child care related examples.

2. Everyone's moral beliefs, of course, follow a developmental pattern. See reference 3.

3. For important considerations on the teaching of values, see Lawrence Kohlberg, "Moral Education in the Schools: A Developmental View." For discussions of values and therapeutic agents, see Macklin; also, Charlotte Buhler, Values in Psychotherapy (New York: Free Press of Glencoe, 1962).

4. The New York State Association of Child Care Workers has written and adopted a set of ethics for child care workers, which also has been adopted by the New York State Council of Voluntary Child Care Agencies. See pp. 63-66.

5. This point is taken directly from Macklin, pp. 144-147.

6. Sidney B. Simon, Leland W. Howe, and Howard Kirschenbaum, Values Clarification. See also Howard Kirschenbaum, Advanced Value Clarification (La Jolla, Calif: University Associates, 1977).

7. Simon, Howe, and Kirschenbaum, p. 19.

SESSION OUTLINE: VALUES AND VALUES CLARIFICATION

Time: About 90 minutes

Space: A large room

Equipment: Easel pad, stand, and markers, or chalkboard; participants will need writing surface (tables), paper, and pencils

Handouts: "Self-Assessment: Values," p.60
"Values Forum," p. 61.
"Ethical Standards of Child Care Workers," p. 63

1. Introduction — 10 minutes

The trainer distributes the "Self-Assessment: Values" handout and asks participants to respond to the statements by filling in the "before training" boxes. The trainer explains the importance of repeating the self-assessments in three months and six months after training. After the final assessment, participants are to return the completed form with their comments to the trainer.

The trainer now introduces the topic and shares the purposes and goals of the session with the participants.

2. Discussion-presentation — 15 minutes

The trainer presents materials on the definition of values, the importance of values, the sources of values, the values interacting in child care, and the various methods of clarifying values. This is material the workers are familiar with and have ideas about. The trainer can elicit this material from the participants themselves by asking questions about the respective issues to be covered (e.g., "What are values? What do *you* mean by values?" etc.). Any answers given can be recorded on a flip chart or chalkboard and be referred to at appropriate points later.

3. Exercises: Valuing

The following exercises are designed to illustrate for participants the process of valuing, which is explained later in the session.

a. Prizing Exercise — 10 minutes

The participants are asked to list, for their own use, five things they really like about their job. The trainer can then ask for volunteers to share their lists with the whole group.

b. Choosing Exercise — 10 minutes

First, the participants are asked to imagine that they could alter their present jobs any way they see fit; the only catch is that they are allowed to retain only two of the five things about their jobs they listed in the first exercise. They are given time to write down their choices. Again, volunteers are asked to share their choices with the group.

c. Acting Exercise — 30 minutes

First, if the group is large, the trainer should divide it randomly by having participants count off. Each group is assigned the same task, with a separate topic. Participants are given the "Values Forum" handout. Each group is to choose one values issue from that handout (or select an issue not listed there) and discuss it as directed in the handout. Then, each group is to write a child care ethics statement concerning that issue. Time is purposely short (about 15 minutes) for this part of the exercise. Next, the large group reconvenes and each group reports on its ethics statement. The trainer moderates the discussion. (The handout "Ethical Standards of Child Care Workers" can be distributed at this point.)

4. The Process of Valuing - Brief Talk — 15 minutes

The trainer explains the theory of values clarification, relating each major part of the process to the relevant exercise completed by the participants. Emphasis is on self-awareness for the professional child care worker.

5. Summary — 5 minutes

A handy way to summarize this session is by having participants write down two things they learned or discovered or rediscovered about their values during the session. Again, volunteers are asked to share what they have written; and the session is over.

Alternate Strategies

The possible variations for a values clarification session are probably infinite from a training perspective. The behavioral objectives have to be kept in mind; the session, if changed, still has to achieve the behavioral objectives, or else new behavioral objectives need to be written.

For alternate exercises in values clarification, see the literature in the bibliography of this module.

Here are some ideas for alternate training:

1. A role play could be designed for the opening of the session. It could center, for example, on a worker who insists that some treatment issue must be resolved in a certain way, while others disagree. The role play could be structured to illustrate values conflict, and the trainer could lead discussion afterward, focusing on the influence of values and the importance of being aware of that influence. The rest of the session could follow appropriately.

2. Participants could be divided into small groups at the beginning and asked to brainstorm specific issues: defining values, influences of values on action, sources of values, and so on. The rest of the session could follow appropriately.

3. For the acting exercise (preceding page), the groups could be given the option of presenting a role play of a values conflict around the issue they choose to discuss. If this is done, the trainer should ask groups to come back with a constructive proposal for dealing with the conflict. This exercise would take more time than that given in the original outline.

Just to repeat: Whatever change is made, remember the required match-up between activity and training objective.

ANNOTATED BIBLIOGRAPHY

Kohlberg, Lawrence. "Moral Education in the Schools: A Developmental View." In *Adolescent Behavior and Society: A Book of Readings*. Edited by Rolf Muus. New York: Random House, 1971.

Kohlberg's moral development theory is important for anyone working in human services; it has all sorts of implications for treatment, teaching, self-awareness, and other dimensions of caring. This article discusses the failure of traditional methods of teaching values and Kohlberg's own views on that issue. See also his "Moral Education for a Society in Moral Transition," in *Educational Leadership*, October 1975. Kohlberg's views match the theory of values clarification very well.

Macklin, Ruth. "Values in Psychoanalysis and Psychotherapy: A Survey and Analysis." *The American Journal of Psychoanalysis* 33 (1973): 133-150.

Dr. Macklin is a philosopher who has written extensively on issues in mental health and psychotherapy. This article provides the whole framework and model for the discussion in the resource paper of values that intersect in the child care situation. It is clear and well written and contains many references that will give the interested reader a good start on the related literature.

Simon, Sidney B.; Howe, Leland W.; and Kirschenbaum, Howard. *Values Clarification: A Handbook of Practical Strategies for Teachers and Students*. New York: Hart, 1972.

This book contains an abundant supply of useful exercises for participants of all ages. Since the editors group them by age level, the book is useful for both child care training and child care work.

HANDOUTS

SELF-ASSESSMENT: VALUES

This form is for you to use as a measure of what you get out of training; it is also useful for the trainer to evaluate the training. So please be candid in your responses.

Choose the number on the scale that most closely represents your level of activity for each of the following two statements. Write that number in the appropriate box below. Repeat this process at three months and again at six months following training.

a. I make an effort to determine the influence of my personal values on professional decisions and to make sure that influence is appropriate.

b. In my professional activities, I make an effort to identify and clarify values conflicts I encounter.

1	2	3	4	5	6	7	8	9	10
never	occasionally			sometimes			often		always

	a. Influence of personal values	b. Identify and clarify values conflicts
1. Before training		
2. Three months after training		
3. Six months after training		

If you do not see an increase in the frequency of your efforts, try to figure out why. Your answer to that question will help you utilize training and will help improve future training.

VALUES FORUM

Choose one of the following topics that involves values issues with which CCWs most constantly deal. Use the questions following each topic as a guideline for discussion of the value laden decisions made around these issues in child care.

1. Drugs and Medication

   Would you ever take Valium, Librium, or alcohol to calm your nerves? If not, would you take one if a doctor said it was necessary for your health?

   Do you prefer working with a child who is made more manageable by medication?

   What is the real purpose of medicating kids?

   How do you tell a child not to take drugs if you take them?

2. "Therapy"/Psychotherapy

   If someone recommended that you seek professional counseling how would you react?

   What do you think of the ability of therapists to help people solve their problems?

   Under what circumstances would you recommend psychiatric help for a child in your care, if ever?

   Is the therapy you (the CCW) give the child sufficient, or does he or she need more?

3. The Natural Family

   What is your personal opinion of families that abuse or neglect their children?

   If there is no opportunity for foster care or adoption, is it better for the child to stay in an institution or return to a family that is "not so hot"?

   If a family said it did not want its child to return home, would you allow the family to visit the child at the agency?

   Do you think that home visits should be taken away as a disciplinary action?

4. Privacy

What would your reaction be if you were searched by an administrator when you came to work?

What would you have done if your parents had read all of your mail?

Should kids be able to have their own place to lock personal possessions?

5. Discipline

How were you disciplined as a child? Was it good for you? Is it good for the kids in your care? Why or why not?

Are punishment and discipline the same thing? Explain.

What types of discipline should be allowed with children in your care?

ETHICAL STANDARDS OF CHILD CARE WORKERS

Association of Child Care Workers, Inc.*

A child care worker believes in the dignity and worth of the individual child. He is committed to increasing a youngster's understanding of himself and others and, as a professional worker, to promoting the full development of a child's potential.

He does not use his professional position or relationships nor does he knowingly permit his own services to be used by others for purposes inconsistent with these values.

I. RESPONSIBILITIES

A. As a professional child care worker, he is aware of and facilitates the delivery of services geared to each child's physical, medical, emotional, social, spiritual, recreational, educational, and vocational needs.

B. As a professional, he demonstrates through action and involvement his unique skills for the art of living. Through a conscious use of his own behavior and the behavior of the children, he helps the child towards a healthier adjustment to life.

C. A child care worker has a responsibility to guide and structure the child's life and environment; because of this, the child care worker must maintain professional objectivity and self-discipline, so that each child's needs remain his primary focus.

D. A professional child care worker recognizes his obligation to assist others to acquire knowledge and skill and to maintain competence and high ethical standards.

E. A child care worker has the obligation to further his knowledge of the profession through professional readings and further education.

F. As a professional, he is aware of and sensitive to a profound social responsibility because his work intimately touches the lives of others.

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* Used by permission.

II. COMPETENCE

Because of a child care worker's purpose to facilitate the delivery of services to children, it is paramount that he maintain a high degree of competence in the field of child welfare.

A. A professional child care worker is in a unique position in relationship to the delivery of services to children. He therefore possesses the knowledge and competencies in child care and should assist the child welfare systems in defining their goals and directions.

B. In addition, a professional child care worker, in relation to child caring agencies, should promote the establishment of a therapeutic atmosphere conducive to the healthy growth and development of children in care.

C. A professional child care worker should assist educational institutions in the development of child care curricula and training programs. In addition, he should, as a consultant and advisor, participate in the supervision, evaluation, and modification of such programs, so that high professional standards are achieved and maintained.

D. A professional child care worker discourages the practice of child care by unqualified persons and assists educational and child caring agencies in identifying child care workers competent to give dependable, professional services.

E. A professional child care worker attempts to rectify violations of ethical standards by other child care workers, fellow professionals, or the child caring agency itself.

III. MORAL AND LEGAL STANDARDS

A child care worker in the practice of his profession has a direct influence on the local community and society at large. It is, therefore, imperative that moral and legal standards be strictly adhered to.

A child care worker realizes that violations of accepted moral and legal standards damage the relationships with the children under his care as well as impugn his own name and the reputation of his agency and profession.

IV. CONFIDENTIALITY

A child care worker is obligated to safeguard information about the child and his family that has been obtained in the course of his professional practice. Such information may only be shared with others who are involved with the child and family on a professional basis. In addition, such information must be shared in a professional manner and only when it serves the best interest of the child.

V. ADVOCACY OF CHILD'S RIGHTS

A child care worker, because of his comprehensive responsibility for the total welfare of the children in his care, must work to ensure that each child's legal rights are not violated or denied and that his human rights are respected.

A. A child care worker, recognizing each child's rights to his concern, manifests that concern in a demonstrable way.

B. A child care worker, because of his awareness of individual and group dynamics, is in a key position and has a corresponding obligation to attempt to harmonize conflicts arising from the group living situation.

C. A child care worker respects and encourages appropriate parental involvement.

D. A child care worker is dedicated to the development of each child's independence and reintegration into his community within the shortest time possible.

E. A child care worker works to ensure that co-workers, fellow professionals, and the agency respect the child's and parents' rights.

VI. INTERPROFESSIONAL RELATIONS

A child care worker, in recognition of the importance of other related disciplines in the delivery of services to children, is obliged to cooperate with and support the integration and delivery of these services by other professionals.

VII. RESEARCH AND PUBLICATION

A child care worker has the responsibility to add to the professional body of knowledge through research and publication. Research must be done within moral, professional, and legal standards and guarantee the confidentiality and welfare of the subjects involved.

70

VIII. RESPONSIBILITY TOWARD ORGANIZATION

A child care worker realizes that institutions, agencies, and systems have been created to serve the needs of large numbers of children and parents. In attempting to meet the needs of individuals and small groups, he realizes the necessity of supporting and aiding the efficient and productive functioning of such organizations.

A. A child care worker respects the rights, reputation, and philosophy of the organization for which he provides service.

B. A child care worker has the responsibility to promote and support the goals and purposes of his professional association.

Human Growth and Development

by Patricia O'Donnell, Anne Stea, and Mary Armstrong

INTRODUCTION

Child care workers profit from a familiarity with human development theory because it assists them in assessing a child's abilities. Children in residential care often cannot be expected to function on the psychological and physiological level of their chronological age. Because of early deprivations and losses, these children have not gained skills that are associated with a particular developmental stage; they are often dealing with the tasks of an earlier stage. By realizing what skills and tasks a child has or has not mastered or resolved, the child care worker can be a therapeutic agent in the child's development.

A child care worker needs to recognize that he or she is also in a process of development. Using insights about both the child's and his or her own development, the worker can be more effective in helping children and adolescents grow.

This module provides the new child care worker with a general introduction to psychosocial development, based for the most part on Erik Erikson's theory of human development. The worker is given both an opportunity to analyze personal feelings about the life tasks with which he or she is dealing and practice in identifying which stage a child is experiencing by examining that child's behaviors. The worker is encouraged to identify and learn about his or her own developmental stage.

Given the huge amount of material pertaining to human development, some decisions had to be made about what to include in a training session. This module focuses on what is generally called psychosocial development. To do partial justice to this topic, the training is presented in a long session that can occupy a day. Other aspects of human development, e.g., physical development, are omitted. This in no way implies that such topics are unimportant for child care. Trainers who wish to do so are encouraged to develop training activities relating to this and other topics falling within the domain of human development. In this way, the curriculum can be used as a stimulus from which additional training can grow.

In addition to a brief resource paper pertinent to the suggested training session, a number of outlines and descriptions of human development are included. Some or all of these may be used as handouts for participants.

BEHAVIORAL OBJECTIVES

At the end of this session, participants will be able to

1. Recognize that their own current developmental stages and tasks affect on-the-job behavior.
2. Identify their own developmental stages and the main developmental issues and crises of those stages.
3. Identify the developmental stages from infancy through adolescence in terms of characteristics and tasks.
4. Given a case presentation and outline of developmental stages and tasks, identify the developmental stages and tasks in which the child or adolescent is engaged.

BEHAVIORAL CHANGES

1. Through awareness of his or her own developmental stage, the worker will be conscious of its effects on work performance. Specifically, the worker will attempt to use the positive aspects of his or her developmental stage and to minimize the negative characteristics.
2. In verbal and written communication, the worker will be able to assess the child's or adolescent's developmental stage according to human development theory. This ability will be shown in reference to the child's attempts at carrying out the tasks of development and in the worker's provision of situations and feedback appropriate to the child's development.

RESOURCE PAPER: HUMAN DEVELOPMENT

Simply put, theory and research in human development are pertinent to child care workers for two reasons. First, the stage of life one is living through affects all aspects of life, including job and job performance. As a professional in human relations, the child care worker requires an ability to focus on and control the effects his or her own life has on professional interactions. Second, and more obviously, a significant factor in knowing how to work with children is knowing how children develop. In residential settings, a crucial portion of child development is psychosocial development, which is the focus of this training module.

When we talk about human development here, we are discussing a stage theory. A stage theory can be compared to building blocks. Each layer of blocks provides a foundation for the next level. Each stage in Erikson's model lays the groundwork for the next stage. Erikson's theory claims to be universal; all human beings experience the same stages, without cultural or sex differences. All individuals go through the same sequences, although at different rates. Each stage has a crisis or central problem task to be solved. The crisis of each stage must be successfully resolved before the person can move to the tasks of subsequent stages.

The psychologist Jean Piaget, who did extensive work on learning theory, saw crisis as positive. He felt the "challenge aspect" of crisis is critical for movement. Unless there is disequilibrium between the environment and self, there is no motive for change. The disequilibrium is caused by some sort of imbalance between the way the individual would like the world to be and the way it presents itself to him; this imbalance can be in the emotional realm or in the social, cognitive, or moral realms. Thus, a strategy for movement between developmental stages is one that causes the individual to recognize the disequilibrium or crisis and then to accommodate to it by changing his or her behavior. The crisis decenters people, which helps them to look at something from another perspective.

Erikson's theory has been discussed at length in many places in the literature.* Thus, we will skip a detailed discussion of his views in order to examine some more recently published discussions of adult development, some of which are based on Erikson's theory.

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* For Erikson's own formulation, see "Eight Stages of Man," Childhood and Society, Chapter 7 (New York: Norton, 1950), and "Identity and the Lifecycle," Monograph, Psychological Issues 1, no. 1 (New York: International Universities Press, 1959). For a good presentation of Erikson's views, see Henry W. Maier, Three Theories of Child Development (New York: Harper and Row, 1965).

Relationship of Adult Stages to Child Care

It has been commonly accepted for many years in the field of child/adolescent development that children and adolescents normally experience critical periods of disequilibrium that are basic to continued growth and development. Recent research by Sheehy, Levinson, and others has demonstrated that adults likewise experience sequential, predictable stages of development that greatly affect a person's values and behavior regarding such issues as personal achievement, expression of feelings, male/female roles and relationships, adult/child roles and relationships, and vocational choices.

All of the personal processes and choices set in motion during each developmental stage influence occupational patterns, e.g., career choices, the relative importance of work, the need for achievement, and monetary success. Even more influence is evident in the helping professions, where self-awareness and personal development are so connected with the professional use of oneself in helping others.

Young Adulthood

Erik Erikson describes the crisis of young adulthood as "intimacy vs. isolation." The young adult, emerging from the search for self-identity, is now ready to fuse that identity with others. This readiness for intimacy, defined as the capacity to commit oneself in concrete affiliations and partnerships, is played out in close affiliations, sexual unions, admiration for mentors, and self-awareness. Previous sexual experience has been identity-searching; it now can include the intimacy of sexuality.

As is noted by Sheehy and Keniston, this is also a time to resolve many issues related to taking part in an adult world and becoming congruent with existing society - issues such as vocation, social role, life-style. Sheehy observes that the young adult typically takes one of two approaches: (1) to build a firm, safe structure for the future by making strong commitments, or (2) to explore and experiment in a transient manner, thus keeping any structure tentative and therefore easily reversible. This choice (locked in vs. transient) sets in motion a life pattern that will influence each adult stage.

During this stage it is common to observe a high value placed on change and movement, alternation between efforts to change self and efforts to change society, feelings of omnipotence contrasted by feelings of disconnectedness, isolation, and impotence. Resolution is found through the ability to acknowledge self and society without denying either. These youth stage characteristics are often profiled in young child care workers - middle- or upper-class college graduates or dropouts who feel compelled to temporarily "drop out of the system" in order to have a respite for examining occupational and value options. Child care work provides the forum for a personal search for meaning in a setting committed to human caring and involvement. Child care is also advantageous because it encourages self-growth through interaction with staff and clients.

Not only can child care work have a positive effect on the young adult, but also his or her characteristics at this stage can positively influence child care performance. These characteristics include (1) a strong commitment to the growth and development of the children in care and their families that often produces the willingness to go "that extra mile" with a seriously disturbed child; (2) a high level of energy and enthusiasm in approaching the endless tasks of "the other twenty-three hours"; (3) a marked effort to view and respond to each child in care as an individual rather than according to stereotypes or roles; (4) an openness to self-growth and change, especially as they relate to skill development or a more professional use of oneself. Effective supervision often facilitates and enhances the already present process of self-examination and development.

On the other hand, the young adult can negatively influence professional child care performance: (1) the young adult tends to develop a social group exclusively composed of others from the same stage and life-style; this often gets translated into intolerance of older, "more straight" staff; (2) there is often an external similarity with adolescents in care regarding manner of dress, jargon, music, and approved life-styles. The young adult child care worker may assume an equality of development with these adolescents in cognitive, moral, political, sexual, and psychological matters that is actually not present. When the adolescents do not respond at the expected level, the child care worker often experiences surprise and disappointment; (3) the young adult is often in conflict regarding his relationship to the existing adult world and therefore is reluctant to assume an "adult" authoritarian role. The needs of the disturbed child and adolescent for guidance, controls, and support may be overlooked in the name of individual freedom and the right of self-direction. Similarly, the young child care worker may look to adolescents for peer group support, rather than realizing that the adolescent views him not as peer but as clearly different - older, although not necessarily adult.

Adulthood

Erik Erikson labels the adult crisis as "generativity vs. stagnation." This crisis often begins in the adult's early thirties with a feeling that life has become more difficult and painful than it was. Both personal and career choices made during the twenties now appear too narrow and restricting. A common response is to "tear apart" a life previously put together. Divorce or change in occupation or life-style may result. Almost always there is a serious review of previous choices and how they now fit with personal aspirations and values. Typically a man has already proven his work competency and wants to shift interest to other areas of development; a woman who has been family-oriented now needs to broaden her horizons and return to school or work.

Occupational choices often now become an issue, especially for male child care workers. Lack of a career ladder, low pay, inadequate personal benefits are viewed as serious impediments causing discontent and apathy. The financial stresses of raising a family cause serious concern. If the options of either a career ladder or educational leave are not available, the worker may switch to another profession. Even if his or her occupational choice remains stable, disruptions in other life arenas may "spill over" into the work situation.

Another critical point during middle adulthood is usually reached between the ages of thirty-eight and forty-five. Some theorists view this as an "acutely unstable period" marked by much personal discomfort. This is the "authenticity crisis" when each person must reexamine purposes and reevaluate priorities. Parts of the self that have been until now suppressed seek to find expression. A reintegration of one's identity occurs, which is comparable to the adolescent's search for self-identity. This crisis usually comes into focus through normal physiological and psychological development: faltering physical powers, grieving for one's own dying youth, the fading purpose of stereotyped roles, awareness of the inevitability of death as life becomes restructured in terms of "time left to live." Women usually reach this crisis at an earlier age (around thirty-five) with the realization that this is the final opportunity to review the option of childbearing. Men usually experience similar feelings of restlessness, confusion, and boredom around the age of forty.

Again, during this developmental crisis there may be departures from solidly based life-structures, such as marriage and career. Often a person may retain a primary interest in the human services field but desire vertical (supervisory or administrative) or lateral (teaching, training, writing) moves out of direct practice. The availability of such options may be the deciding factor in vocational decisions.

Middle Adulthood

Between the ages of forty-three to fifty a person's equilibrium is usually regained as one enters into a settling down, roots-building period. The important task is to find renewed purpose in developing a more authentic life structure, rather than resigning oneself to standing still as previous safety and supports are torn away. There is a new valuing of one's spouse as a source of warmth and companionship, of one's friendships, and of one's privacy. A child care professional in this developmental stage contributes to co-workers and clients a sense of stability, caring, and self-acceptance.

According to Erikson, the overall task of the life cycle is to achieve ego integrity - to accept one's individual life cycle and that of family and friends as experiences that convey world order and spiritual sense. Within this developmental process of taking responsibility for one's own life, each stage is a catalyst for personal choices and changes that affect the child care worker's professional development.

SESSION OUTLINE: HUMAN DEVELOPMENT

Time: 5 hours

Space: A large room; 3-4 smaller rooms, if possible

Equipment: Easel pad, stand, and markers
Projector and screen

Materials: "Fantasy Trip: Adolescence," p. 79
Film: first reel of Everybody Rides the Carousel
Handouts:
- "Self-Assessment: Human Development," p. 84
- "The Eight Stages in the Life Cycle of Man," p.85
- "Erikson's 'Eight Stages of Man,'" p. 87
- "Adult Life Stages," p. 88
- "Adult Life Stages Exercise," p. 90
- "Tasks of Adolescence," p. 338
- "Ray Q - A Case Example," p. 10
- "Adolescent Development," p. 91
- "How a Baby Grows," p. 95
- "Developmental Table for Children Ages 3-15 Years," p. 101
- "Adult Development," p. 104

Notes:

(1) Since this session is longer than a half day, a convenient place to break for lunch is noted after #6. For a full day's training, lengthen or add activities.

(2) The last four handouts listed are included as supplementary information for both trainer and participants and as handouts for possible alternative training sessions on human development.

1. Introduction 10 minutes

The trainer distributes the "Self-Assessment: Human Development" handout and asks participants to respond to the statements by filling in the "before training" boxes. The trainer explains the importance of repeating the self-assessments at three months and six months after training and asks participants to return the completed form with their comments to the trainer after the final assessment.

The trainer introduces the topic of human development and specifies the focus of the training (psychosocial development). The main objectives of the activities - awareness of one's own developmental stage and the ability to identify the developmental stages of the children in care - are presented, along with other more specific objectives that the trainer and group may have derived.

2. Presentation: Stage Theories 15 minutes

The trainer presents three main concepts pertinent to stage theories: stage, crisis or task, and decentering (see resource paper). The two handouts on Erikson's eight stages may be distributed now or at the end of the session.

3. Small Group Exercise: Adult Stages 40 minutes

Reminding the participants that adults are also in the midst of a developmental process (and perhaps mentioning some of the current popular publications, e.g., Passages, by Gail Sheehy), the trainer then asks them to familiarize themselves with the handout "Adult Life Stages." After an adequate time for reading the handout (five to ten minutes), the trainer has the participants divide themselves into small groups according to the adult life stages in which they feel they currently belong.

Participants of each group spend the remaining time discussing the worksheet "Adult Life Stages Exercise." Each group will need a recorder who will report to the larger group. As usual, the participants should be encouraged to develop creative ways to report their discussion findings; for instance, groups may like to organize their reports around a song or book title that summarizes what it's like to be that age, e.g., for the "Thirty Transition Group": War and Peace.

4. Processing the Small Group Exercise 30 minutes (or more for larger groups)

Each group reports its findings about being at that particular stage of development. Here the trainer has to make a special effort to draw out the implications for child care workers of their own adult developmental stage. Much of this material bears directly on (1) the need for the worker to be aware of his or her own "crisis" and response to it so that difficulties arising from it are put in the proper perspective rather than becoming job problems; and (2) the constructive and conscious use of the developmental stage to enhance the worker's job.

BREAK 15 minutes

5. Fantasy Trip: Adolescence 30 minutes

The trainer makes a few introductory comments about adolescent development, the difficulty of working with adolescents, and so on. Then the idea of a fantasy trip is introduced; its purpose is to have the participants get in touch with their own adolescence - what they were then feeling, thinking, and doing - as a means of looking at the psychosocial tasks that adolescents are working on.

The trainer has the important job of making the situation safe for all participants, since such remembrances can sometimes be upsetting.

First, speaking softly, the trainer assures the group that there will be no interruptions or intrusions during the brief "trip," *and makes sure there are none!* Second, the trainer creates an atmosphere in which the participants can feel at ease - lowering or turning out lights, closing doors, etc. - so they can delve into their memories. Perhaps most important the trainer assures the group that no one will be asked to share anything he or she does not wish to share.

After giving these reassurances, the trainer directs participants to relax, close their eyes, and turn their focus inward, thinking about their bodies, relaxing muscles, and breathing deeply.

For the actual fantasy trip, the trainer uses the directions and questions given on pp. 79-80. For the trainer's benefit, the questions are categorized into four major tasks of adolescence, but they may be developed differently in the presentation.

At the end of the fantasy, there must be a transition time for the people to come back to an outward focus. The trainer can say the questions are over and tell participants they have a few moments to redirect themselves. Then the lights can be turned on (rheostats are very handy at this session). Finally, the participants can be asked to choose someone else in the group with whom they feel comfortable and to share some thoughts and reactions to the fantasy.

6. Processing the Fantasy Trip

30 minutes

The handout "Tasks of Adolescence" (p. 340) is distributed. After participants have a chance to examine it, the trainer leads a discussion of the tasks, using the experience of the fantasy to focus on each task and how it was resolved for them. Participants should not feel forced to share thoughts about their own adolescence.

The discussion can be channeled in many different ways; e.g., it can be a comparison of how adolescents today are coping with the same tasks. Reference can be made to the handout to point out that different ways of coping with the tasks may be problematic without being in any way abnormal.

BREAK OR LUNCH

7. Film on First Three Stages

a. Introduction to *Everybody Rides the Carousel*

5 minutes

This is an animated film that describes and illustrates the first three stages of Erikson's theory of human development. (Only the first reel of *Carousel* is needed; the other reels cover later developmental stages.) Throughout the film, symbols such as lions, kittens, etc., are used to highlight the challenges and crises of each stage. The movie presents the struggles of conquering developmental tasks through the eyes of the child, helping the viewer experience these struggles as the child does. Although the participants have already worked hard in this session, the film should not be used as a break. The main group can be divided into three lesser groups, each having an assignment:

Group 1 -	Get a total picture of Erikson's first three stages, but pay special attention to stage 1 (trust vs. mistrust) and what factors helped the child accomplish the task.
Group 2 -	Get a total picture of Erikson's first three stages, but pay special attention to stage 2 (autonomy vs. shame and doubt) and what factors helped the child accomplish the task.
Group 3 -	Get a total picture of Erikson's first three stages, but pay special attention to stage 3 (initiative vs. guilt) and what factors helped the child accomplish the task.

b. Showing of Carousel 25 minutes

c. Discussion 10 minutes

The three groups briefly discuss their respective stages. The trainer solicits any overall comments.

8. Small Group Activity: Ray Q 15 minutes

The purpose of this activity is to use the concepts of human development, as presented in the earlier activities, in assessing the development of a child in care. The "Case History: Ray Q" handout (p. 10) is distributed, and participants are divided into four groups. The groups are assigned stages of development as follows:

Group 1: stage 1
Group 2: stages 2 and 3
Group 3: first two tasks of adolescence
Group 4: second two tasks of adolescence

Each group is asked to list the behaviors indicating that Ray is working on the tasks of the group's assigned stage of development and to give one way in which child care workers can assist Ray in resolving the issues of that stage. Each group will report its findings.

9. Processing the Small Groups and Summary 45 minutes

Each group reports its findings in turn. The trainer can then summarize the training on human development, emphasizing that this session is introductory - there is much more information on this topic that can benefit child care workers. The participants can then write "I learned" statements, and volunteers can share theirs.

FANTASY TRIP: ADOLESCENCE

(The trainer poses the following questions in a relaxed manner, pausing after each question to give participants a chance to reflect. Questions have been categorized into the four tasks of adolescence for the trainer's benefit. The trainer should read the instructions on pp. 76-77 before using this trip.)

I am taking you back to your sophomore year in high school. You were 14 or 15. Think back to that time in your life.

Physical Development

1. What did your body look like?
2. Were you proud of it?
3. How did your development compare to your friends?

Heterosexual Development and Peer Relationships

4. Who were your friends - mostly girls or boys?
5. Were you popular?
6. Did you belong to a clique?
7. Were you involved in a lot of activities?
8. When did you start dating?
9. Can you remember your first date?
10. Did you feel pressured to do things you didn't feel were right?
11. Who could you talk to about sex?
12. What did your peers know? What did they do?
13. What were your parents' attitudes about sex?

Dependency/Independency

14. Did your parents treat you like an adult or a child?

15. Did they ever talk to you about money, plans, or decisions?

16. Did you feel close to them?

17. Did you feel encouraged by them to make your own decisions?

18. Did they help you to be independent - like giving you driving lessons, etc.?

19. Did they pressure you about college or a career?

Defining One's Identity

20. Did you know what you wanted for a career - did you stick to it?

21. Did you have idols or heroes you wanted to copy? Who were they?

22. Did you agree with your parents on most issues?

23. Were there things that your parents did that you definitely did not want to do when you grew up? Why?

(The trainer gradually brings participants back to the present, turns on lights, and gives them a minute or so to return to the present.)

ANNOTATED BIBLIOGRAPHY

7

Erikson, Erik H. *Childhood and Society*. 2nd ed. New York: Norton, 1963.

Erikson's theory of the eight ages of man is detailed in this profound work on childhood development. What he has to say is valuable for all child care workers who are being called on to assess children's developmental needs.

This is a difficult text and is not recommended for all readers. An interesting section in terms of child care was the one comparing child-rearing practices in different cultures. The traits that are valued by a society are taught through specific parenting techniques.

Trainers might find this useful for a more in-depth understanding of Erikson's approach to development.

Kohlberg, Lawrence. "Moral Education for a Society in Moral Transition." *Educational Leadership*, October 1975, pp. 46-54.

This is one of Kohlberg's best discussions of his stage theory of moral development. It is of use to child care workers who deal with any age group above 10, especially adolescents. It is also of use to trainers and supervisors.

Levinson, Daniel. *The Season of a Man's Life*. New York: Knopf, 1978.

A recent and interesting presentation of adult male development. Levinson and his associates studied intensively the lives of forty men and used that and additional research as the basis of their picture of adulthood. This important work influenced Gail Sheehy in her writing of *Passages*. While the book can be extremely valuable in terms of a man's self-awareness, it is limited by the fact that it does not attempt to study adult female development - a project which Levinson and his associates have undertaken.

Maier, Henry. *Three Theories of Child Development*. New York: Harper and Row, 1969.

This is an excellent book for child care workers. It is divided into three major parts, each devoted to the developmental theory of one major theorist. Erikson's views are the subject of the first part, those of Piaget the second, and Sears' learning the third. Together, these three theories form a valuable, solid base of knowledge from which the worker can enhance the care of children. Recommended for both trainers and workers.

Mussen, Paul; Conger, John; and Kagan, Jerome. Child Development and Personality. 4th ed. New York: Harper and Row, 1974.

One of the standard textbooks on child development. It covers all aspects of child development and it is very readable. Its main drawback is that it is a general textbook and as such is limited in its treatment of child care issues. Still, it is of high quality as a general introduction.

Sheehy, Gail. Passages. New York: Dutton, 1974.

Based on extensive research of others in the area of adult development, plus hundreds of interviews, Sheehy has popularized the concept of predictable crises of adulthood. She has put theories like Erikson's into her own developmental jargon. Sheehy, unlike Levinson in Seasons of a Man's Life, studies both men and women; she also puts strong emphasis on the experiences of progressing through these stages. Though some would criticize the book as superficial "pop-psych," it has much to offer as an introduction to adult development and an aid to enhancing self-awareness.

Stea, Anne. Residential Child Care: A Reader. Albany: Continuing Education Program, School of Social Welfare, State University of New York at Albany, 1978, pp. 22-43.

The pages listed are a detailed description in outline form of human development, including developmental stages from infancy through old age.

HANDOUTS

SELF-ASSESSMENT: HUMAN DEVELOPMENT

This form is designed to be both a useful measurement and monitor of the benefits you acquire from the training session and a feedback instrument for the trainer to evaluate the training. For both of these uses, it is crucial that your responses be as forthright as possible.

Choose the number on the scale that most closely represents your level of activity for each of the following three items. Write that number in the appropriate box below. Repeat this process at three months and again at six months following training.

I make it a point to

a. try to determine the developmental tasks each child is currently living through

b. determine how and when each child resolved previous developmental tasks

c. try to be aware of the impact of my own developmental stages on my decisions and activities

1	2	3	4	5	6	7	8	9	10
never		occasionally		sometimes			often		always

	a. Children's current tasks	b. Children's previous development	c. My own developmental stage
1. Before training			
2. Three months after training			
3. Six months after training			

The desired pattern of responses for the above items is, of course, an increased level of activity following training. If you do not see such an increase in your activity three and six months after training, try to figure out why, both for your own professional development and for the improvement of future training.

THE EIGHT STAGES IN THE LIFE CYCLE OF MAN

Erik H. Erikson

"Personality," Erikson has written, "can be said to develop according to steps predetermined in the human organism's readiness to be driven toward, to be aware of, and to interact with a widening social radius, beginning with a dim image of a mother and ending with an image of mankind...." Following are the steps he has identified in man's psychosocial development and the special crises they bring. In presenting them he has emphasized that while the struggle between the negatives and positives in each crisis must be fought through successfully if the next developmental stage is to be reached, no victory is completely or forever won.

I. INFANCY: Trust vs. Mistrust. The first "task" of the infant is to develop "the cornerstone of a healthy personality," a basic sense of trust - in himself and in his environment. This comes from a feeling of inner goodness derived from "the mutual regulation of his receptive capacities with the maternal techniques of provision" - a quality of care that transmits a sense of trustworthiness and meaning. The danger, most acute in the second half of the first year, is that discontinuities in care may increase a natural sense of loss, as the child gradually recognizes his separateness from his mother, to a basic sense of mistrust that may last through life.

II. EARLY CHILDHOOD: Autonomy vs. Shame and Doubt. With muscular maturation the child experiments with holding on and letting go and begins to attach enormous value to his autonomous will. The danger here is the development of a deep sense of shame and doubt if he is deprived of the opportunity to learn to develop his will as he learns his "duty," and therefore learns to expect defeat in any battle of wills with those who are bigger and stronger.

III. PLAY AGE: Initiative vs. Guilt. In this stage the child's imagination is greatly expanded because of his increased ability to move around freely and to communicate. It is an age of intrusive activity, avid curiosity, and consuming fantasies that lead to feelings of guilt and anxiety. It is also the stage of establishment of conscience. If this tendency to feel guilty is "overburdened by all-too-eager adults," the child may develop a deep-seated conviction that he is essentially bad with a resultant stifling of initiative or a conversion of his moralism to vindictiveness.

Adapted and abridged from "Youth and the Life Cycle" by Erik Erikson, appearing in *Children* (March-April 1960).

IV. SCHOOL AGE: Industry vs. Inferiority. The long period of sexual latency before puberty is the age when the child wants to learn how to do and make things with others. In learning to accept instruction and to win recognition by producing "things," he opens the way for the capacity of work enjoyment. The danger in this period is the development of a sense of inadequacy and inferiority in a child who does not receive recognition for his efforts.

V. ADOLESCENCE: Identity vs. Identity Diffusion. The physiological revolution that comes with puberty - rapid body growth and sexual maturity - forces the young person to question "all sameness and continuities relied on earlier" and to "refight many of the earlier battles." The developmental task is to integrate childhood identifications "with the basic biological drives, native endowment, and the opportunities offered in social roles." Identity diffusion is temporarily unavoidable in this period of physical and psychological upheaval. The danger is that this identity diffusion may result in either a permanent inability to "take hold" or, because of youth's tendency to total commitment, a negative identity fixation, i.e., a devoted attempt to become what parents, class, or community do not want him to be.

VI. YOUNG ADULTHOOD: Intimacy vs. Isolation. Only as a young person begins to feel more secure in his identity is he able to establish intimacy with himself (with his inner life) and with others, both in friendships and eventually in a love-based mutually satisfying sexual relationship with a member of the opposite sex. A person who cannot enter wholly into an intimate relationship because of the fear of losing his identity may develop a deep sense of isolation.

VII. ADULTHOOD: Generativity vs. Self-absorption. Out of the intimacies of adulthood grows generativity - the mature person's interest in establishing and guiding the next generation. The lack of this results in self-absorption and frequently in a "pervading sense of stagnation and interpersonal impoverishment."

VIII. SENESCENCE: Integrity vs. Disgust. The person who has achieved a satisfying intimacy with other human beings and who has adapted to the triumphs and disappointments of his generative activities as parent and co-worker reaches the end of life with a certain ego integrity - an acceptance of his own responsibility for what his life is and was and of its place in the flow of history. Without this "accrued ego integration" there is despair, usually marked by a display of displeasure and disgust.

ERIKSON'S "EIGHT STAGES OF MAN"

Stage	Crisis	Approximate Age	Positive Resolution	Negative Resolution
1	Trust vs. Mistrust	First year	Sense of basic trust	Suspiciousness, fear, inwardness
2	Autonomy vs. Shame & Doubt	1 - 3 years	Sense of control over oneself and one's environment	Obsessiveness, rigidity, self-doubt
3	Initiative vs. Guilt	3 - 5 years	Imaginative, goal-directedness	Guilt, suspiciousness, lack of spontaneity
4	Industry vs. Inferiority	6 - 12 years	Sense of duty and accomplishment, competence	Sense of inadequacy, poor working habits, tendency to avoid competitive situations
5	Identity vs. Role Confusion	Adolescence	Feelings of unity and purposeness, self-certainty	Inability to "fit in," self-consciousness, confusion over values
6	Intimacy vs. Isolation	Early Adulthood	Ability to share love and closeness with another	Emptiness, loneliness, tendency to avoid intimacy
7	Generativity vs. Stagnation	Middle Adulthood	Sense of productivity (work, family, self)	Nonproductiveness, lack of fulfillment of expectations
8	Ego Integrity vs. Despair	Late Adulthood	Sense of satisfaction with one's life, acceptance of life cycle and life style	Inability to deal with impending death, lost faith in self and others, feelings of incompleteness about one's life

ADULT LIFE STAGES

Early Adulthood (17-40)
(Intimacy *vs*. Isolation)

Life Stage	Developmental Tasks
Early Adult Transition (17-22)	- Autonomy from parents - Career choice - Forming adult identity
Young Adulthood (22-28)	- Social role identity - Intimacy - Occupation choice
30 Transition (28-33)	- Reevaluation of career choice - Reevaluation of relationships - Reevaluation of life style
Late Young Adulthood (32-39)	- Career development - Raising a family

Middle Adulthood (40-60)
(Generativity *vs*. Stagnation)

Life Stage	Developmental Tasks
Mid-Life Transition (36-45)	- Reevaluation of all previous adult choices - Reevaluation of personal values and aspirations - Development of ethical self
Early Middle Adulthood (44-50)	- Raising adolescent children - Career development - Caring for aging parents
50's Transition (50-55)	- Reevaluation of life - Loss of parents - Children leave home

Later Middle Adulthood (53-60)	- Spouse as companion/mutual support - Development of leisure time

Late Adulthood (60+)
(Ego Integrity vs. Despair)

Life Stage	Developmental Tasks
Late Adulthood Transition (60-65)	- Redirection of energy - Acceptance of time - Acceptance of one's life - Awareness of physical decline
Late Adulthood (65-80)	- Retirement - Life style changes - Death of spouse/friends - Illness
Late Late Adulthood (80+)	- Acceptance of death - Sensory functions/health decline - Involvement with self

Adapted from:

Erikson, E. Childhood and Society (2nd ed.). New York: Norton, 1963.

Levinson, D. The Seasons of a Man's Life. New York: Knopf, 1978.

Sheehy, G. Passages: Predictable Crises of Adult Life. New York: Dutton, 1974.

ADULT LIFE STAGES EXERCISE

INSTRUCTIONS: Based upon the developmental tasks (not ages) contained in the "Adult Life Stages" handout, determine the stage that best represents you. Form a group with others experiencing the same stage and, together, discuss the following questions.

1. Why did you choose this particular stage?
2. What events or changes have occurred in your life during this stage? For example:
   a. Occupation
   b. Relationships
      - marriage
      - family
      - self
      - friends
      - institutions
   c. Social Roles
      - worker
      - boss
      - lover
      - spouse
      - parent
      - friend
      - citizen
      - group member
3. How does it feel to be in this stage? Why?
4. What would you have to do to complete this stage successfully?
5. What do you like most about this stage?
6. What do you like least about this stage?
7. What specific effects does being in this stage have on your role as a CCW?

NOTE: These questions are designed to facilitate, not limit, discussion. Feel free to explore other related issues. Each group will report on their discussion when we reconvene.

ADOLESCENT DEVELOPMENT

I. Overview

For practical purposes we are looking at adolescence as the period between ages thirteen and seventeen, even though theorists have expanded the time span from thirteen to twenty-two. The reason for this is that most of the children in our care are basically within the thirteen and seventeen age range.

One of the problems in treating adolescents is clearly determining what is typical and appropriate behavior and what is pathological. There are no clear-cut limits for measuring the functioning of an adolescent to know when his or her behavior is dysfunctional. Some theorists believe, in fact, that adolescence is a period of dysfunctional behavior, while other theorists are less extreme, believing that some stress and turmoil are innate to the period. We choose to define adolescence as a time of pressure and conflict. There is pressure from within the adolescent sparked off by physiological change and pressure from outer cultural and social/familial expectations. At times these pressures and conflicts are tolerable and manageable and at other times they are disruptive and antagonistic for the adolescent (and us!).

In viewing adolescence as a time of stress, there are three things that we as care-givers should keep in mind. First, we should not view adolescence strictly from our reflection on our own pasts, but in terms of the adolescent's present (society, values, and culture have changed). Secondly, we should evaluate the adolescent's functioning according to normative expectations rather than personal expectations. Finally, we need to avoid "my way" authoritarian approaches at the one extreme and "do your own thing" approaches at the other extreme. No matter what the adolescent may say to us about his or her autonomy and desire to be totally independent, he or she does require structure and guidance to feel safe.

II. Developmental Tasks

A. Overview - According to the Eriksonian model there are eight developmental tasks of adolescence. For purposes of clarity and usefulness, these tasks have been combined into four broad categories. Although these categories represent distinct and separate features, many of the tasks overlap.

B. The four developmental tasks

1. Physical maturation - characterized by rapid growth spurts, elaboration of primary and secondary sexual characteristics, maturation of the reproductive system, and psychological changes.

a. Psychological changes that create conflict
   1) onset of sexual impulses - fears about masturbation, about being perverted or homosexual
   2) conflict over control of sexual impulses

b. Social conflicts caused by rapid or delayed maturation
   1) early maturation - others may place the adolescent in a position of being considered emotionally mature. The adolescent may be viewed as a leader and given responsibility beyond his/her abilities. Physically mature girls may be embarrassed and may be viewed as being sexually active even though they are not.
   2) late maturation - may cause isolation or social stress because the individual is not as interested in the opposite sex as his/her peers are. Adolescent boys can feel inadequate and become more volatile and rebellious (proven in studies).

2. Heterosexual and peer relationships - characterized by development of social skills and sex role identity. Best friends, cliques, and transient crushes are common as well as romanticism and idealism. There is an attempt to conform to peer group (norms, styles, attitudes). The adolescent looks to his/her peers rather than parents for approval.

   a. Psychological conflict - because of the maturational lag between girls' development and boys' development boys can sense a feeling of lowered self-esteem.

   b. Social conflict - the group may not accept the adolescent or be acceptable to him/her. This causes alienation and depression.

   c. Familial conflict - the parents may add stress by dictating whom the adolescent can associate with or by judging (perhaps unfairly or tactlessly) the peers the adolescent has.

3. Independence and separation from family - characterized by the adolescent attempting to adopt an adult role and seeking vocational skills and skills for independence (e.g., driving). Also, there is a development of personal values and morals that may challenge parental beliefs. The adolescent begins to view his parents as individuals and personalities (and sees all too clearly their faults).

a. Cultural conflict - although the adolescent is encouraged to be more independent, he/she lacks the privileges of adults (voting, getting jobs and loans, etc.).

b. Familial conflict - parents may overreact to the independence by becoming rigid and dictatorial because of their own need to provide sustenance and supervision.

c. Psychological conflict - rather than having responsibilities and independence allocated in degrees, the adolescent may be faced with a burden of decision-making beyond his/her ability (we as child care workers can fall into this trap, expecting the youngster to reach goals or make decisions that maybe even we can't reach). The adolescent may react with hostility or frantic behavior or a sense of low self-esteem and frustration.

4. Defining one's identity - characterized by great self-analysis and introspection, asking such questions as "Who am I?" "Where do I belong?" The adolescent tries different roles (sometimes two or three within a one-hour period) and sees himself/herself as different from parents and peers. This is a development of formal operational thought, including an ability to abstract, to think about cause and effect, to think about what might be, and to form principles.

a. Psychosocial conflict - there is a tendency to be egocentric, believing that "everyone is watching me." The adolescent feels "onstage" and thinks that everyone is judging him/her, which makes him/her touchy to criticism. The adolescent loses perspective of others and objectivity.

b. Cultural conflict - the adolescent can refuse to adapt to any socially acceptable role, therefore becoming alienated, depressed, and delinquent. It seems that there is nothing the child cares about.

C. Strategy of Adaptation - The three components of the coping process are

1. Ability to gain and process new information
problem - since the adolescent is egocentric and introspective, seeing the world as being his/her audience, he/she is unable to see the world objectively and process new information accurately.

2. Ability to maintain control over one's emotional state
   problem - the adolescent is highly volatile and cannot tolerate a lot of anxiety. Instead he/she wants immediate gratification and is sensitive to criticism.

3. Ability to move freely in one's environment
   problem - adolescents are often restricted by parents as to where they can go, who they can associate with, etc. In a placement situation, the adolescent is further confined by rules, routines, and the location.

D. Summary - Having viewed the developmental tasks and conflicts of adolescence, you can see that a broad range of behaviors and feelings fall within the "norm." To determine what is dysfunctional and functional in the behaviors exhibited by the adolescents in your care, look at the severity of the conflicts and pressures and maybe that will help you to sort out your adolescent's needs.

HOW A BABY GROWS*

A Look at Body, Hand, Speech, and Social Development at Different Stages

Babies are not alike. They differ in appearance, in the ways they feel about things, and in the ways they learn. They also differ in the ways they move and even in the speed of their development. For example, one baby may develop more quickly in certain areas than others of his age. But he'll follow the same general pattern that all normal babies do.

You'll notice that a baby's development may not be steady. It will go forward, then stay the same for a while - or even appear to go backward - before continuing on again. This, too, is normal.

Birth to 2 Months

BODY DEVELOPMENT. Just after a baby is born, her wobbly head may look too large and may even be lopsided from the pressures of delivery. That soft spot in her head will gradually fill in as the skull grows. It will not close until she is about 12 to 15 months old. A new baby's ears, back, and shoulders are furry, but this will disappear in a few months. Her skin is wrinkled, loose, and ready to scale. Her eyelids are puffy, but her eyesight is better than most people believe. She sees simple patterns, follows slow-moving objects, and likes to look at faces. She sees best at a distance of 8 to 10 inches.

HAND DEVELOPMENT. A new baby has automatic reflexes. You will notice particularly the hand-to-mouth reflex. Her grasp is surprisingly strong--again, this is automatic. She'll learn to control the use of her hands many months later.

SPEECH DEVELOPMENT. The only language newborns know is crying. They cry for a special reason: to make adults pay attention to their needs. At birth, babies cry without tears. From the beginning, parents should talk to their babies. Soothing, gentle sounds - and funny, exaggerated ones - can be a great source of comfort.

SOCIAL DEVELOPMENT. A new baby likes soft, high-pitched voices and will quiet down when she hears them. Gentle touching, holding, and rocking will quiet her when she cries. She's sensitive to the feelings of others. If mother or father is tense, she can feel this and may become tense herself.

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* Adapted from a wall chart developed by Johnson & Johnson Baby Products Company. Used by permission. Johnson & Johnson has available a number of fine free materials on infant care and development. Johnson & Johnson Baby Product Company, 220 Centennial Avenue, Piscataway, New Jersey 08854.

2 Months Old

BODY DEVELOPMENT. Now he can use his eyes to follow you several feet across the room. You can pull him slowly by his hands to sit up. When he's on his stomach, he can lift his head. His motions are smoother now. Sometimes he may look as if he were trying to crawl, but actual crawling will come at another time. He uses his entire body to hit at the toys over his crib.

HAND DEVELOPMENT. He sucks his fingers, and he also circles one hand around the other.

SPEECH DEVELOPMENT. He has a particular cry that brings you to his side. He also gurgles and coos. He is more likely to gurgle and coo when you talk to him. At first, he will respond as you are talking. Gradually, he will learn to take turns talking with you.

SOCIAL DEVELOPMENT. Around this age, he lets you know when he wants to be fed. He smiles at pleasant situations and turns to familiar voices. Now, when he's fussing, you can distract him. He is becoming more interested in things outside himself.

4 Months Old

BODY DEVELOPMENT. When you pick her up, she feels more put together--less floppy. She seems more in control of her little body. When you prop her up, she can keep her head steady, and she looks around in various directions. She may enjoy being pulled to a standing position, and she also may like splashing in her bath. She may be starting to teethe. Some babies will cry for a few days before teeth start breaking through the gums. Others won't experience much discomfort.

HAND DEVELOPMENT. She watches her fingers and plays with them. She looks at each hand separately, grabs one hand with the other, and then pulls them apart. She reaches for her toys.

SPEECH DEVELOPMENT. Of course she still cries. But now she also laughs out loud. She coos, gurgles, and chortles for joy. She can say "ooh" and "ah." She sometimes has one voice for her father and another for her mother.

SOCIAL DEVELOPMENT. Just about now she loves to be played with and pulled to sit. She fusses to make you come to her, and then lets you know that she wants to be picked up. She can tell the difference between family members and also chooses some toys over others.

You may find that at this stage she becomes anxious when she sees strangers.

7 Months Old

BODY DEVELOPMENT. A baby can now sit up by himself for a short time. He has begun to crawl, pulling himself forward by moving his arms together and dragging his legs and stomach along the floor. With the help of furniture he pulls himself up to stand. He may even begin to crawl on his hands and knees.

HAND DEVELOPMENT. His little hands are busy. He likes to pick things up and drop them only to pick them up again. He may use one hand more than the other. He holds his toys and also feeds himself pieces of food. He tries to use his thumbs and forefingers.

SPEECH DEVELOPMENT. He imitates sounds. He talks to himself in the mirror and smiles at and pats his reflection in the glass. His vocabulary is growing; it includes coos, squeals, and combined vowel sounds. And his responsiveness to your sounds is also growing. By this time, he is paying more attention to your mouth than to your eyes when you talk. This shows he has become interested in how you talk.

SOCIAL DEVELOPMENT. He may become attached to a particular toy. He'll try to follow his parents when they leave the room. If there are other children in the family, he enjoys their company and tries to please them, but he can also play happily alone. Bath time is play time - one of the most pleasant of the day for him. This is a very important time in the bonding between parent and infant. Through contact and touch, your baby can feel your love and thus feel more secure. And that's so vital to his development.

10 Months Old

BODY DEVELOPMENT. The 10-month-old baby may continue to practice her crawling. Or she may be a racing crawler and climber who tries the stairs and starts practicing walking.

HAND DEVELOPMENT. She likes to eat whole meals with her fingers and uses one hand more than the other.

SPEECH DEVELOPMENT. She's learning words like "no" and "bye-bye," and she practices them. She says "Da-da" and "Ma-ma" and has a good time playing "peek-a-boo" and "pat-a-cake."

SOCIAL DEVELOPMENT. She is learning to be independent. She may practice going away from you and rounding a corner, only to return to you quickly. She has special toys she likes to carry with her. She finds it fun to help with her dressing and undressing, and she seems to understand other people's moods more and more.

12 Months Old

BODY DEVELOPMENT. If he's still crawling, he changes from a crawl to a tottering walk with his legs wide apart. He likes to climb into your lap.

HAND DEVELOPMENT. He feeds himself finger foods now. He unties his shoes and may even help to wash himself. He likes to put his spoon into his cup. Fitting one thing inside another gives him an understanding of "bigger" and "smaller." This is how he begins to learn about spatial relations. Now he can play a simple game of ball, grasping it and letting it go.

SPEECH DEVELOPMENT. His vocabulary is growing. Besides "Da-da," "Ma-ma," and "Ba-ba" and, of course, "no," he's using more complicated words. He probably can tell you what he wants. How well he does it depends on your practicing his new skill with him. He's most likely to imitate the words you say if you add some playful actions that he can also imitate - banging, for example.

SOCIAL DEVELOPMENT. He loves an audience. He enjoys applause and will repeat anything that gets it. He's showing emotions like jealousy, affection, and sympathy and may even show a sense of humor. He loves rhythms and is a tremendous imitator. He's learning a great deal all at one time; that's a strain, so he may have an occasional tantrum, and you will want to comfort him as soon as he runs out of steam.

15 Months Old

BODY DEVELOPMENT. She's very active. She's walking better. Her feet are more parallel, and she can pick up things from a walking position without falling. But she's still very much a baby with her back that curves in and her tummy that curves out.

HAND DEVELOPMENT. She loves to throw things. She's recently learned to let go of things, and throwing is a natural result. She can let go of one block and pick up another to make a simple tower. She can put things into containers.

SPEECH DEVELOPMENT. She adds gestures to her own special baby language, which shows that she soon will really speak. She now says words like "ta-ta," for "thank you."

SOCIAL DEVELOPMENT. She's much more aware of her surroundings and more interested in them. She's all over the house and seems to love wastepaper baskets. She finds it fun to pull things out and, less often, to put them back in. She likes to listen to music and dance in rhythm to it, and even to look at a picture book with the help of her mother or father. Yet her growing independence and activity are balanced by her growing demands. She starts to "test"

103

her parents, perhaps by refusing food. This strain of negativism is quite natural and offers an excellent chance for you to start teaching your baby some limits of behavior.

18 Months Old

BODY DEVELOPMENT. He's so full of energy that he runs into nooks and corners, up and down stairs and all around the house. He walks with his feet wide apart and runs with a stiff gait. His little arms extend away from his body, and he uses his whole arm when he plays ball. He still has to learn good coordination of his hands and feet. He has a wonderful time lugging, tugging, dumping, pushing, pulling, and pounding. All these actions follow one another quickly.

HAND DEVELOPMENT. He eats with a spoon and fork and tries a knife. He can take off his shoes, hat, and mittens and unzip a zipper. He likes to close doors, flush the toilet, mop up a puddle, and hand his dish to you when he is finished.

SPEECH DEVELOPMENT. He's adding personal pronouns. He doesn't pronounce the consonants at the ends of words. "Chair" is "chai," and "cat" is "ca." His favorite words may be "all gone" and "thank you" and others that mean completion. He can understand the directions you give him, but you must back them up for the most part by actions.

SOCIAL DEVELOPMENT. He's into everything. His wish for independence grows stronger. He may often refuse food just to show this. He's interested in how the household works and where things are kept, but when the new experiences become too much, he's apt to return to his pet toys for comfort. This is an exciting and interesting time for him, and when both parents take turns looking after him this gives him fresh views of relating to people. This sharing also helps you, as parents, to understand your baby more and relieves some of the natural tension that comes from dealing with a child in an especially busy growing period.

24 Months Old

BODY DEVELOPMENT. Around this age she cuts her last baby teeth. She still doesn't walk erect. Her knees and elbows are slightly bent, her shoulders are hunched, and her arms are held out and back. She leans forward as she runs. She's much better at going up and down stairs, and she can kick a ball. It will be another year before she can pedal a tricycle.

HAND DEVELOPMENT. She handles her spoon and fork well. She can turn a doorknob and even copy a circle on paper. She likes to take things apart and put them together or fit one object inside another.

SPEECH DEVELOPMENT. She speaks better and is replacing her baby language with sentences. She likes to talk to herself, to repeat words, to name things, and to combine her words with actions. Her vocabulary may be anywhere from six to a thousand words. This is the beginning of a year of great language development.

SOCIAL DEVELOPMENT. She's still full of "no's." Learning so much at once is hard on her; as a result, she may have a tantrum from the strain. She's very busy now, identifying with the world around her. She enjoys helping both Mom and Dad with work around the house. She may enjoy picking up after herself.

DEVELOPMENTAL TABLE FOR CHILDREN AGES 3-15 YEARS*

Ages 3-4 Years The child will be able to

- climb stairs using alternating feet
- begin to button and unbutton clothing
- use plurals, personal pronouns, and verbs in answering questions
- respond to a command on where to place a toy
- draw a geometric shape representing a person
- identify his/her own sex
- give first and last name
- copy a circle already drawn
- feed self at mealtime
- take off shoes and jacket

Ages 4-5 Years The child will be able to

- run and turn without losing balance
- stand on one leg for ten seconds
- button clothes and lace, not tie, shoes
- count to four by rote
- differentiate two items from within a group of four
- draw a person with a head, two appendages, possibly two eyes, but no torso
- recite the days of the week
- explain what to do if he/she is sleepy, hungry, or cold
- take care of self at toilet, except perhaps wiping
- play outside for at least thirty minutes
- dress self, except for tying

Ages 5-6 Years The child will be able to

- catch a ball
- skip smoothly
- copy a "+" already drawn
- say his/her age
- count out ten items, perhaps count higher by rote
- differentiate between right and left hand
- draw a recognizable person with at least eight details
- describe a favorite television program in some detail
- do simple chores at home
- go to school unattended or meet school bus
- handle motor activities well, but will not be aware of dangers

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* Adapted from "Use of Developmental Charts in Teaching Well Child Care" by S. R. Leavitt, H. Goodman, and D. Harvin, Pediatrics 31 (1963): 499. Used by permission.

Ages 6-7 Years The child will be able to

- copy a triangle
- describe what to do with specific objects
- differentiate between morning and afternoon
- draw a person with twelve details
- read several one syllable words
- print name with a pencil

Ages 7-8 Years The child will be able to

- count by twos and fives
- tie shoes
- copy a "diamond-shaped" mark
- identify today's day of the week, but not the date or year
- read and understand a four sentence paragraph, containing simple sentences and one syllable words
- add and subtract single digit arithmetic
- articulate correct speech patterns
- draw a person with sixteen details

Ages 8-9 Years The child will be able to

- define objects better than just by use of that object
- know what to do if he/she has damaged others' property
- know how to respond if he/she is unintentionally hit by playmate
- read and understand an eight sentence paragraph, containing primarily simple sentences, but at least one complex sentence of mainly one syllable words
- add and subtract double digit arithmetic, including borrowing and carrying processes

Ages 9-10 Years The child will be able to

- say the month, day, and year
- name the months in order
- make a sentence with three given words in it
- read and understand a paragraph containing six sentences, including some complex sentences with mainly one syllable words
- add and subtract four digit numbers
- multiply a three digit number by a one digit number

Ages 10-12 Years The child will be able to

- read and understand a six sentence paragraph, including dates, proper nouns, statistics, and comparisons
- multiply a three digit number by a two digit number
- divide a two digit number by a one or two digit number

Ages 12-15 Years The child will be able to

- read and understand a seven sentence paragraph, including proper nouns, dates, statistics, geographic areas, multisyllable words, and complex sentences
- divide a four digit number by a three digit number
- add and subtract fractions

ADULT DEVELOPMENT

I. Young Adulthood (17-40)

A. Growth Processes

1. Physical milestones
   a. reaches sexual maturity
   b. reaches peak of physical capacity

2. Cognitive milestones
   a. peak of mental capacity
   b. high level moral thinking

3. Social milestones
   a. ability to love
   b. stabilization of ego identity

B. Developmental tasks

1. Embarking on a career and/or continuing one's education
2. Searching for a congenial social group
3. Learning to manage a home and assuming household responsibilities
4. Courting and selecting a mate for marriage
5. Socialization into adult roles
6. Raising a family

C. Psychosocial crisis - intimacy vs. isolation

1. Resolution of crisis
   a. positive - ability to share love and closeness with another
   b. negative - emptiness, loneliness

II. Middle Adulthood (40-60)

A. Growth processes

1. Physical milestones
   a. individual reaches full physical maturity
   b. hair does not grow as rapidly
   c. skin is no longer able to stretch quite so tightly over the muscles
   d. menopause
   e. visual acuity and cardiovascular capacity may decline

2. Cognitive milestones
    a. majority of people reach the height of their creative and productive capacities

3. Social milestones
    a. reaches full social maturity
    b. integration of ethical self

B. Developmental tasks

1. Establishing and guiding the next generation
2. Adjusting to aging parents
3. Accepting and adjusting to the physiological changes of middle age
4. Achieving social and civic responsibilities
5. Developing leisure-time activities
6. Working productively and creatively
7. Adjusting to children leaving home

C. Psychosocial crisis - generativity vs. stagnation

1. Resolution of crisis
    a. positive
        1) sense of production
        2) care (working for the benefit of others)

    b. negative
        1) lack of fulfillment of expectations
        2) nonproductiveness

III. Late Adulthood (60+)

A. Growth processes

1. Physical milestones
    a. graying or loss of hair
    b. wrinkling of the skin
    c. loss of teeth
    d. high frequency hearing loss
    e. decline in visual activity
    f. decline in muscle strength

2. Cognitive milestones
    a. decline in recent memory
    b. slowing down of performance speed

3. Social milestones
    a. retirement
    b. loss of spouse, friends, family members
    c. diminishing income

B. Developmental tasks

1. Redirection of energy to new roles
2. Acceptance of one's life
3. Developing a point of view about death
4. Dealing with decreasing physical strength
5. Acceptance of time

C. Psychosocial crisis - ego integrity vs. despair

1. Resolution
    a. positive
        1) sense of satisfaction with one's life; acceptance of life style and cycle

    b. negative
        1) inability to deal with impending death; feelings of incompleteness about one's life

Adapted from:

Erikson, E., Childhood and Society, 2nd ed. (New York: Norton, 1963).

Levinson, D., The Seasons of a Man's Life (New York: Knopf, 1978).

Loss, Separation and Placement

by *Patricia O'Donnell and Mary Ellen Deighan*

INTRODUCTION

An understanding of loss and separation is essential to child care workers, since it is a recurring theme in the lives of children in care. Everyone experiences losses, from brief separations from loved ones for vacations, hospitalization, education, and so on, to major disruptions like divorces and death. How well one deals with these experiences is dependent on one's resolution of past losses.

Children who come into residential treatment have not had the opportunity to work through the pain and grief connected with the many separations often encountered in their short lives. The natural mourning that needs to be expressed is often neglected, only to come out later as rage or severe depression, at times when others consider it unexplainable and inappropriate. Child care workers need to become experts at diagnosing the symptoms and stages of loss and separation. The children they work with need assistance in maneuvering through the process. They need the support and assurance of empathetic and trained workers, who will view their feelings as normal and teach them more acceptable behavioral expressions of grief.

Child care workers are in the unique position to intervene in the child's daily routines and to use these opportunities to teach children skills in coping and competence in dealing with loss.

The material presented here explores a worker's own response to loss, various theories of the grieving process and how they apply to a child in placement, and treatment tasks and techniques regarding loss and separation. The hope is to stimulate workers' thoughts so that they will begin to assess a child's needs in this area and to develop treatment plans to satisfy these needs.

BEHAVIORAL OBJECTIVES

After participating in this session, workers will be able to

1. Describe behaviorally their responses to a personal loss and understand how personal loss experiences affect their professional role.
2. Identify the four phases of the grieving process and explain that the phases are not cut and dried but overlap and repeat, given a running record of a child in placement.
3. Identify at least three appropriate child care tasks relating to the child's grieving process, given a running record of a child in placement.

BEHAVIORAL CHANGES

1. The child care worker will evaluate how personal separations have affected his or her own behavior and will accept that these experiences affect his or her professional role.

2. The child care worker will detect the phase of the grieving process that a child in placement is experiencing and will express this assessment at meetings and in logs and records.

3. The child care worker will design plans and implement methods for helping children work through the grieving process.

RESOURCE PAPER: LOSS, SEPARATION, AND PLACEMENT*

There are a number of theories today about separation and loss. The theorists agree that there is a universal response to loss. Here we will take some time to present different theories and show how these theories represent similar patterns of responses.

Let us briefly examine the meaning of loss and grieving. We define loss as the situation that occurs when someone or something meaningful to a person is taken away. Grieving is the process of adjusting to a loss; it continues over a period of time and has certain identifiable stages or phases.

The universal responses to loss include anxiety, regression, and increased dependency. These responses occur whether the loss is temporary or final, real or imagined, unplanned (such as a death) or planned (such as a move or change in jobs).

In the 1940s, Eric Lindemann studied persons who lost close relatives in the Coconut Grove fire in Boston or through other tragedies. He identified many common responses in the acute grief reactions of these adults. Most of the adults in Lindemann's study experienced somatic responses to loss: choking sensations, a tightness of the throat, shortness of breath, loss of appetite, and exhaustion. Emotionally, there was a preoccupation with the image of the deceased. All the person's thoughts and energies were so preoccupied with the lost person that there was a sense of unreality in the everyday world and an emotional distancing from other persons. Guilt over real or imagined failures in the relationship with the deceased was also commonly experienced as well as feelings of anger, irritability, and restlessness. The adults studied often directed their feelings toward other persons in their environment and were upset by it. Lindemann noted that a person was reaching the final stage of the grieving process when he or she could disengage from his or her preoccupation with the deceased and engage in continued or new relationships in the environment. Lindemann added that a major obstacle to completing the grieving process was the tendency to avoid expressing the emotions that accompany it.[1]

Dr. Elizabeth Kubler-Ross has studied the response patterns of persons confronted with the anticipated early loss of their own lives. Working with hospital patients who were dying of terminal illnesses, she identified five basic stages in a person's response to the discovery that he or she is dying. The initial response is denial; the person is in a state of unfeeling numbness. Kubler-Ross feels that this state of shock is a necessary temporary reprieve that gives the person time to mobilize energies to face the loss. The next stage is anger; the person resents what is happening to him or her. The person then enters a bargaining phase in which he or she attempts to find ways to get his or her life extended. (As you may note, the lack of reality, denial, and anger seen here is similar to Lindemann's findings.) In both theories, the person appears to be restructuring his or her reality either by being preoccupied with his or her relationship to the deceased or by looking for ways to extend his or her own life. The next phase of Kubler-Ross's model is marked by depression as the person finally faces reality and considers the meaning of death and the many losses it involves. The final stage is acceptance of death, which is usually characterized by passivity and gradual withdrawal as the person's circle of interest slowly diminishes.[2] In the Lindemann model, the individual gradually withdraws from the deceased and readjusts to the environment and remaining relationships.

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* The discussion of separation and loss theories is adapted from Mary Armstrong, "Placement and Loss: Implications for Child Care Treatment," Residential Child Care: A Reader, Continuing Education Program, School of Social Welfare, State University of New York at Albany, pp. 51-59.

John Bowlby and Carolyn Thomas have both studied grief and mourning in infants and young children separated from their families. Bowlby identified three basic stages. The initial response he labeled as protest; during this stage the child reacts vigorously to the loss through anger and rejection of his new environment. The next reaction is one of despair; the child withdraws into himself and demonstrates sadness and grief over the loss of the loved object. Bowlby's final stage is called detachment, in which the child emancipates himself or herself from the loss and begins to adjust to the new environment.[3] Carolyn Thomas, in her study of loss among foster children, identified these same stages and added a preprotest stage characterized by denial and a lack of response to the loss.[4]

Here again, in comparing the stages of grieving identified by Bowlby and Thomas with Lindemann and Kubler-Ross, a common pattern is discernible. Typically one will see phases of denial, anger, guilt and despair, acceptance and adjustment. Overlying the entire process is the grief work itself - the coping that takes place as the person actively involves himself or herself in facing and working through his or her grief. It is important to note that although the phases are chronological, all of the emotions may need to be experienced and expressed repeatedly before the final stage of adjustment is achieved. In order to complete the grief work all stages must be experienced - neither rushed nor avoided.

For our purposes we will concentrate on these theories in relation to the institutionalized child. This child often experiences losses ranging from temporary placement in foster homes to extended placement in treatment centers, to possible final separation from natural parents through court order. In terms of emotional development, we are talking about children who have experienced so many unresolved losses that the past interferes with their ability to cope with current loss (i.e., present placement). This child has less capacity to deal with loss than an average child. The average child reacts to change but usually isn't capable of talking out these feelings. Behavior is his or her expression of inner stress that he or she cannot put into words. The child may become physically ill, refuse to attend school, act moody or preoccupied. Children in placement often carry these behaviors further. They deal with these feelings through aggressive acts or extreme withdrawal.

Along with the child's emotional capacity for dealing with loss, we also need to look at the child's past losses of relationships. A child may have formed a close relationship with someone and then lost it, or may never have formed a relationship at all. After a relationship is formed, change is critical. Any prolonged separation at this point has serious effects on the child. In extreme situations, this separation can damage a child's capacity for making strong attachments.

For the child who has never experienced a relationship, the ability to develop a sense of basic trust is greatly impaired. At first glance, this child may seem well adjusted. He or she is friendly to strangers and often on the surface seems to have a strong attachment with numerous people. However, the slightest disturbance will cause this child to react intensely toward the people in his or her environment. He or she has not learned trust and thus tests out each person until he or she proves that the person is not trustworthy.

We, as workers, need to keep in mind that placement is loss. Each child who comes into the unit is struggling to deal with the loss of his or her parents. A parent may reject a child, but a child rarely rejects the parents. Next, we will look at how loss theories can be used to assess stages of loss and what we can actually do to aid children with their grief work.

Please refer to "Stages of Loss and Separation," p. 130; as you can see, associated with each stage is a list of correlated feelings and behaviors that a person might exhibit during that stage. When assessing individual cases of children in care, being aware of those feelings and behaviors would be helpful. For example, when a child who first enters an institution's cottage shows no signs of disturbance and actually acts happy to be there, we can make educated assumptions that the child is probably at the preprotest or denial stage of loss and separation. A child who seems fixated on going home and attempts to do so by running away at every opportunity is probably dealing with the protest or anger stage. By observing the behaviors of children and then matching them to the universal behaviors connected with various stages, we can make valid assessments as to what stage the child is in and how to intervene.

How do we intervene? In helping the child do grief work, there are some basic guidelines for child care treatment. It is very common for the placed child to deny his or her feelings about the loss. The first treatment goal is to help the child move beyond the denial. The child needs permission to grieve. The child care worker must be inventive and creative in finding ways to acknowledge the loss, share the child's grief, and affirm his or her right to all the feelings that accompany the loss.

Another treatment goal with the child in placement is to help the child label his or her feelings. Many children do not understand the meanings of angry, sad, or afraid, or the appropriate behavior for such words. Often enough, their only behavioral response to all of these feelings is to act aggressively and destructively. Part of making the grieving process manageable is to sort out, label, and identify the various feelings. Once the child has some words to attach to what he or she is experiencing, the child and the child care worker can share the experience together.

Another basic guideline for the child care worker is to move in tune with the rhythm of the child. The child's behavior will indicate where he or she is in the grieving process; the child care worker's response must be planned accordingly. Even though the overall goal is the stage of acceptance and readjustment, we must respect the individual's timing and rhythm. A related issue is the generalized need to work through the various stages of grieving over and over again. The more damaged the child, the more likely that the working through will need to be repeated again and again. It is during this repetition that the child care worker must continue to respond with consistency, respect, and caring.

An important dynamic operating throughout this process is the child's tendency to identify the child care worker with the parents, whom he or she perceives as rejecting and abandoning him or her. This dynamic often results in misdirected and out-of-proportion anger toward the child care worker, as well as attempts to make the child care worker reject the child. In these instances, the child care worker's awareness of this dynamic helps him or her to "reject the behavior but not the child" and continue to offer to the child his or her caring and empathy.

A child care worker needs to utilize consciously other separation situations to help children with loss. In residential treatment centers many changes occur that children perceive as losses. For example, staff leave their jobs, volunteers and college students terminate their services, both staff and children are transferred between units, and, of course, children terminate placement. Staff need to be open to discussion of their feelings and the children's feelings about these changes. Finding acceptable responses to these changes through role modeling is a difficult but valuable child care tool in promoting growth.

Using cottage procedures and special programs is another useful technique in assisting children with their grief work. Staff have to be innovative and flexible to adapt to the children's needs. Routines that are helpful to the group sometimes are detrimental to a child experiencing loss. The worker's ability to create or eliminate programs is called on. For example, one child may need an incentive program just to complete a simple routine because he or she gets so lost in grief during that part of the day. Another child may not need time alone in his or her room as part of the routine, since it increases his or her depression.

Much judgment and empathy are involved in choosing appropriate treatment approaches, as well as considerable effort, time, and energy. However, if the child does not work through the stages, the placement experience will not be beneficial. This in turn leads to staff frustration and disappointment.

More specific techniques may be required to help a child work through his or her grief. When a worker formulates a treatment plan for supporting a child who is experiencing the stages of loss and separation, he or she needs to consider the following:

1) What behaviors are being displayed by the child? Thus, which stage of loss and separation is he or she experiencing?

2) What is this child's family background, what losses has he or she experienced, and were they resolved?

3) What developmental stage is the child in, what other tasks is he or she working on, and what are his or her capabilities?

4) What are appropriate child care techniques that could be utilized in aiding the child?

An article by Albert Trieschman and Bernard Levine[5] describes a variety of constructive child care responses to loss. The authors' main premise is that workers can use daily events in residential treatment centers to teach competence in dealing with loss. Small losses present worthwhile learning opportunities for children in placement. When a child loses a game, misplaces a toy, or receives no mail, the worker may use these occasions for therapeutic input. Institutional routines also symbolize losses. For example, bedtime often means the loss of exciting stimuli and diversion. As we all know, the child who is experiencing a lot of stress often finds bedtime painful, for now he or she is alone with his or her thoughts, thoughts that can emphasize his or her losses. Often this is the child who causes trouble when all is quiet to avoid those thoughts. Mealtimes are associated with loss of family - the favorite foods the family enjoyed are not there, traditional family rituals and conversations are absent. It's no wonder that mealtime talk in institutions often revolves around children's experiences in families. It is also no surprise how disruptive meals can become.

Trieschman and Levine discuss six general techniques that workers can employ in daily institutional situations:

1) Encourage the child to ventilate feelings of sadness directly rather than just behaviorally. Examples: "It's OK to cry. It's OK to say your thoughts. Your brother will be all right even if you say angry things about him for being able to live at home. Words don't harm people."

2) Help the child to develop a capacity to repress or suppress sadness. At certain times the best thing would be to forget it. For example, the child who becomes immobilized in an academic situation by crying, wandering, and staring into space would do better to submerge his or her sadness while he or she is learning. Children need to discriminate between appropriate and inappropriate times to express their feelings.

3) Teach the child to label his or her feelings. He or she can use these labels then to signal others for help. By knowing the word that describes his or her feeling he or she can communicate with others. They can then anticipate how the child will act and how they might help.

4) Use role plays and improvisations with children to develop self-awareness of feelings and ways of dealing with them.

5) Use the staff's responses to events to show appropriate ways of dealing with sadness. For example: A staff member who loses a game of chess might point out to a child that he or she didn't sweep the men off the board in a rage, but instead joked about the defeat. A worker could share his or her feelings of sadness with the group over a child who is being discharged and tell how he or she plans on writing to the child in order to maintain the friendship.

6) Encourage the child to make partial replacements or substitutes for his or her losses and to develop attachments to new things that give pleasure, such as a new friend or hobby.

As workers, we all have assisted children in dealing with losses, although we may have done these things automatically, without a specific treatment plan. By recalling work with children in care who were specifically there to work out their losses, we (the authors) have compiled a list of activities that child care workers might find useful at different stages in the process and with children of varying ages (see handout, p. 139).

In summation, points to keep in mind are

1) The worker's task is repeated with each child; although the behavior may be different, the feelings will be the same.

2) Understanding the behavior and underlying feelings will give workers more security, release empathetic responses, and increase sensitive communication with the child.

3) Knowledge of loss and the grieving process will also help the worker understand and help the child cope with any additional losses experienced while in placement, e.g., a worker's leaving or a change of cottage or division.

4) Helping the child cope with loss can be both demanding and time consuming. In the long run, however, it is *time saving*, because only when he or she has worked through his or her loss can the child resume progress toward maturity. Placement thus becomes a remedial and growth promoting action, rather than just a "holding tank."

5) If loss is not negotiated, the child will be "frozen out" of hope for future positive relationships. His or her energy will be tied up in maintaining maladaptive defense patterns and he or she will not be able to master new life situations. Instead he or she will have a need to repeat the past; new separations will be viewed and treated as old separations and will reactivate old behavior patterns. Fear of closeness will lead to a self-imposed emotional isolation. Most traumatic of all, he or she could do to his or her children what was done to him or her, continuing the cycle.

6) The reward to the worker is knowing that he or she has helped someone adjust to a difficult situation and minimized the damage, allowing future growth and development.

References (see pp. 125-26 for full listings)

1. Erich Lindemann, "Symptomatology and Management of Acute Grief," in *Crisis Intervention : Selected Readings*, ed. Howard J. Parad (New York: Family Services Association of America, 1961), pp. 9-21.

2. Elizabeth Kubler-Ross, *On Death and Dying*, pp. 38-156.

3. John Bowlby, *Separation: Anxiety and Anger* (New York: Basic Books, 1973), p. 22.

4. Carolyn Thomas, "The Resolution of Object Loss Following Foster Home Placement."

5. Albert Trieschman and Bernard Levine, "Helping Children Learn to Deal with Sadness," pp. 107-113.

SESSION OUTLINE: LOSS, SEPARATION, AND PLACEMENT

Time: About 3 hours

Space: Room for large and small group exercises

Equipment: Easel pad, stand, markers
Felt tipped pens

Materials: "Fantasy Trip," p. 123
Handouts:
- "Self-Assessment: Loss, Separation, and Placement," p. 128
- "Theories of Loss and Grieving," p. 129
- "Stages of Loss and Separation," p. 130
- "Case History: Jim," p. 131
- "Major Events During Jim's Placement," p. 133
- "Worksheet for Assessing Stages of Grieving," p. 138
- "Activities of Help in Dealing with Loss and Separation," p. 139
- "Treatment Implications for Staff, p. 141
- "Bibliography," p. 142

1. Introduction 15 minutes

The trainer distributes the "Self-Assessment: Loss, Separation, and Placement" handout and asks participants to respond to the statements by filling in the "before training" boxes. The trainer explains the importance of participants' repeating their self-assessments at three months and six months after training. After the last assessment, they are to return the completed form with their comments to the trainer.

The trainer begins the session by presenting an overview of the topic and a rationale for training in loss and separation. He or she shares with the participants the training objectives. These may be listed on a flip chart. Points to get across are that loss is a part of growing up, growing old, and dying. For children in residential treatment, however, it is a keynote to their whole life. Loss influences who they are, what they feel, and how they act. Child care workers need knowledge in this area, so that they can use it as a guide to the child's feelings and behavior. Understanding the dynamics of loss and separation gives clues to where and how to intervene with children experiencing the grieving process. The child care worker's role is to respond empathetically to the child and help the child in his or her struggle. In discussing the objectives, participants should understand that placement in residential treatment is being viewed as loss.

2. Large Group Exercise: Fantasy Trip 20 minutes

In order to begin the process of getting in touch with feelings of loss and separation, participants are asked to put themselves into a brief fantasy. The fantasy parallels the experiences of a child being placed in a treatment center. Care should be taken in setting the mood for the fantasy. Dimming the lights and instructions to get comfortable are helpful. After reading the fantasy, the trainer should collect on a flip chart all the responses from the group to the questions listed at the end of the fantasy. Participants often express feelings of anger, disorientation, depression, a desire to hurt their loved ones, hopelessness, etc. All of these feelings are representative of those connected with the stages of loss and grieving. The trainer should emphasize that these feelings are normal and seem to be universal.

3. Pairs Exercise: Separation and Loss 20 minutes

Continuing on the theme of self-awareness, the trainer states that just as in the fantasy trip, participants have probably had the experience of being separated from important people. The reason for the following exercise is to help the participants recognize how they react to and deal with loss. It will also help them know how they respond to others' losses and whether this response could be helpful. The ability to help others handle loss depends to a large extent on how well or how poorly one has resolved or worked through one's own losses. If loss is still a painful area, the natural reaction is to shy away from sharing the child's loss rather than helping him face it.

The participants are asked to think of someone with whom they were very close, someone who has been permanently separated from them in some way. They are then instructed to choose someone in the group with whom they can share this personal loss. The trainer assures the participants that they will not be reporting their loss to the large group. (Participants may choose not to participate in this exercise; those for whom it is too painful, e.g., because of the recent death of a loved one, can leave the room during this period.) After allowing ten minutes for the discussion of personal losses, the trainer directs the pairs to address two questions that are written on the flip chart.

1) What was it like for you to tell someone about your loss?

2) What was it like for you to hear about the other person's loss?

After a few minutes (and after anyone who left the room has been asked to return) responses to these questions are collected in the large group. Participants are asked to volunteer any observations they have. Parallels to their work with children and families are drawn and summarized.

4. Lecture: Loss Theories 30 minutes

The trainer now presents information on theories that have been developed in connection with loss; he or she also defines terms and explores a person's development and response to early losses (see resource paper). To accompany the lecture there are two handouts; one gives a breakdown of three "Theories of Loss and Grieving," and the other is a detailed description of Bowlby's and Thomas's "Stages of Loss and Separation," which is used for the following exercise.

5. Small Group Exercise: Assessment of Loss and Separation Stages

At this point, participants will have an opportunity to develop skills in assessing losses in a typical case history of a child in residential treatment ("Case History: Jim"). The technique of using a case history is employed because (1) it actively involves the participant in applying theory; (2) the case presented can be developed from actual case records, thus involving the worker even more.

a. Task 20 minutes

The large group should be divided into small groups by counting off. The number of groups will depend on the number of participants. The trainer may summarize Jim's case or use it as a handout. The details are not as important as the overview of the child's history up until placement, with emphasis on the separations the child experienced. After sharing the material, the trainer should ask if there are any questions. A handout of the "Major Events During Jim's Placement" is now distributed to each participant as well as the "Worksheet for Assessing Stages of Grieving." The trainer also asks the groups to have the Thomas-Bowlby theory ("Stages of Loss and Separation") in front of them. Time is allotted for participants to read Jim's running record, perhaps five minutes. Each group is then assigned a number of months on the running record. Example: If there are four groups of five, the months are divided into four sections with Group 1 addressing months 1-10 (which were rather uneventful); Group 2 - month 11; Group 3 - month 12; Group 4 - months 13-15. Their task is to decide as a group what stages (as described by Bowlby and Thomas) the child is experiencing during their assigned time period. Each group should appoint a recorder/reporter for feedback to the large group. The worksheet should be used for individual work, and a flip chart sheet duplicating the group's work can be posted during their report.

b. Processing 15 minutes

The trainer has each group report its findings. (Example: Group 1 might report that because of certain events during months 1-10, its members saw the child experiencing a preprotest stage, which moved into protest, then despair. Month 11 is characterized by protest and despair; month 12 despair; and months 13-15 despair and detachment.) Because of different perceptions and interpretations of the material, the trainer may get slightly different results, but the main teaching point is that the stages are not clear-cut, but overlap and can even repeat. Workers need to keep this in mind, so that they don't view a child's behavior as regressive and make the assessment of no progress in a case where the child is actually progressing very well. There is no set period of time for this progress; people will do their grief work at different rates because of their background, development, and the assistance they receive from those around.

Alternative Method

A case history film could be used instead of the printed case history. Several films are devoted to this topic. One that has been used successfully on several occasions is John - 17 Months. The film is available through the State University of New York at Albany, Film Service (LCSB26), 1400 Washington Avenue, Albany, New York 12222.

The trainer could ask the participants to identify the Thomas-Bowlby stages of loss and separation in the film. Groups could be assigned one stage of grieving each to watch for while viewing the film. Each group could then discuss individual observations. Another task that could be used in conjunction with the first is to ask participants to put themselves in the role of the worker and develop a plan for treating the child as he or she experiences the different stages.

BREAK 15 minutes

6. Lecture: Treatment Methods 15 minutes

The trainer presents an overview of child care methods that would be especially helpful in dealing with separation and loss issues. There are many options in doing this section. Lecture materials are included in the last half of the resource paper; these are supplemented by a list of very specific child care plans in the handout "Activities of Help...," which could be displayed on a flip chart or distributed. A handout on "Treatment Implications for Staff" is also included. The trainer may choose to work with all three or to concentrate on one item. The group may add to what is given. Examples: The group might be asked to add to the trainer's list of ideas of how to work on these issues, or the trainer might ask for examples of the guidelines as he or she reviews them from the handout.

7. Small Group Exercise: Developing a Treatment Plan

After having been exposed to ideas on working with children who are experiencing loss, the participants form the same groups as in the last small group exercise.

a. Task — 20 minutes

The task of each group is to develop a child care treatment plan based on the child's stage of loss and separation for the group's assigned months. Examples: (1) During the eleventh month, Jim is in the stages of protest and despair. Child care worker plan: suggest to Jim that he is sad and feeling hopeless about ever getting to go home to live. Perhaps sharing those feelings with a counselor at that time would make him feel he wasn't alone with his problems. (2) In the fifteenth month, Jim is in the stages of despair and beginning detachment. The child care worker might formalize Jim's departure by (a) planning a farewell party, (b) giving him an address book to collect addresses of people he would like to correspond with after he leaves the agency.

b. Processing — 20 minutes

Each small group appoints a reporter/recorder to present its treatment plans to the total group via a flip chart.

8. Summary — 5 minutes

The trainer may review the session by briefly summarizing points that came up in the processing of the content material. An alternate strategy of summing up, especially with a small group, would be for the trainer to ask participants to state one thing that they learned through the discussion on separation and loss. The trainer passes out the "Bibliography" handout as the session ends.

FANTASY TRIP

Instruction to Trainers: The fantasy trip is a very useful, effective teaching technique. It is also threatening to many participants. You must provide safeguards for participants by turning down lights, preventing interruptions, and allowing time for a transition back to the present. Additional safeguards are provided by having participants share feelings at first with only one other person.

After setting the tone for the fantasy, you can read the following in a calm, clear voice:

In order to get you into a certain mind set, I'd like to take you on a fantasy trip. I would like you just to sit back and relax. Think of someone very close to you - someone, maybe, whom you live with, for example, a spouse. If you don't live with anyone right now, I'd like you to think about some loved one and imagine you are living with him or her. Close your eyes, if you want to.

(Pause) I'm going to ask you not to respond until the end.

One day your loved one announces that he or she has a very special mission for you to carry out for him or her.

He or she hands you an envelope and explains that written instructions are contained inside. These instructions are to be read when you arrive at your destination. Your loved one walks you to the taxi he or she has called, speaks quietly to the driver, closes the door after you have entered, and walks to the house without looking back.

You assume that you're being taken to the shopping center, where you will open the envelope and find a list of items to be acquired for your loved one.

As you ride along in the taxi, you notice the streets, signs, trees, and landscape are becoming unfamiliar, completely unrecognizable.

Finally, the taxi pulls up in front of a building you've never seen before. A couple comes out of a large door, whispers something to the driver, and escorts you inside. Walking down the corridor, you suddenly remember the envelope. You fish in your pocket and tear it open, only to find a blank piece of paper.

After being brought to a room, you are told to make yourself at home because there is a need to remain there over a period of time.

After being there a few days, you ask to see your loved one, but no immediate answer is given to you.

Two days later, you are told that your loved one has been detained. He or she has to attend to some important business and won't be able to visit you for a few weeks.

The few weeks turn into a month, and still no personal word or visit. Then, you get a card that reads, "Coming next week, Love...."

Three weeks pass, and still you haven't seen your loved one. During lunch, an attendant leans over to announce to you, "Your loved one is in the waiting room." What goes through your mind?

You don't get to see your loved one and the only reason you get from the attendant is, "We thought this would be better for you."

Days turn into weeks and you keep hearing things like, "This is bedtime, wash your face and hands, brush your teeth, don't drink any water, lights go out in 15 minutes." At other times you hear things such as, "You have got to learn to get along better with others; mix in more; don't be going off by yourself so often; maybe when you stop your crying spells you can go home."

The weeks turn into months - 15 months in all. One morning as you are walking to breakfast, an attendant motions to you and says, "After you have eaten, pack your belongings. In one hour, you're going."

You can hardly concentrate on eating your breakfast. Later, you go to your room and pack. The attendant knocks on your door and asks if you're ready to leave. He walks you to a taxi. As you're getting into the taxi, the attendant says, "Good-bye and good luck." He leans toward the driver and says something to him.

As you drive along, you begin to recognize some old familiar streets and scenery. The driver pulls up to your home. For a moment, you hesitate. Then you get out of the cab and walk up your front path to the door. The front door opens and a neighbor is standing there. There's a number of people who together yell, "Welcome home." You see your loved one walking toward you with opened arms...

How do you feel?

What do you want to say?

What feelings did you have at different times? At the beginning? While you were away? When you came home?

We hope that this fantasy trip gave you some real feelings about the separation and loss issues involved in being "placed away from home." - Developed by Robert Keniston and Mary Ellen Deighan, State University of New York at Albany.

ANNOTATED BIBLIOGRAPHY

Goldstein, Joseph; Freud, Anna; and Solnit, Albert. Beyond the Best Interests of the Child. New York: Free Press, 1973.

A must for all child care workers, but especially those involved in making decisions that affect permanency planning for children in their care. The authors set up a criterion that aids workers in making those difficult decisions about where and with whom a child should live. As they see it, the overall guideline for placement is "the least detrimental available alternative for safeguarding the child's growth and development." Case histories are given that lend support to their argument, as are valuable definitions of the terms we use in discussing family relationships. Workers are also reminded that placement decisions should safeguard the child's need for continuity of relationship, should reflect the child's, not the adult's, sense of time, and that knowledge is limited in making long-range predictions.

Kubler-Ross, Elizabeth. On Death and Dying. New York: MacMillan and Co., 1969.

Although the setting is a hospital and the clients are terminally ill, this book has many implications for child care work. The sensitivity that is demonstrated in work with the dying is an excellent model for staff working with children experiencing loss. I identified with the interdisciplinary team of hospital personnel in their quest for the best way to serve the dying patient and his family. What behaviors on the part of staff did patients find helpful as they experienced the ultimate loss - death? Kubler-Ross evolves a five stage theory on death and dying. There are many parallels to the stages of loss experienced by children being placed outside of their families. Staff responses to the feelings and behaviors of the dying offer ideas on techniques and approaches that would be effective with children who are doing grief work for their many losses.

Littner, Ner, M.D. Some Traumatic Effects of Separation and Placement. New York: Child Welfare League of America, 1967.

This excellent pamphlet, first published in 1956, is still an outstanding resource for understanding the meaning that placement has for a child. Littner emphasizes the key to that understanding throughout his essay: "I would like to remind you of one of the greatest difficulties that we experience in the placement of a child - namely, our problems about seeing things through his eyes, and of adequately understanding and being sensitive to the real meaning of what he is trying to tell us through his verbal and nonverbal behavior." In very readable style, Littner covers all of the essentials in discussion of separation by placement: the emotional meaning of separation from parents; the feelings about new parent figures; how children try to master these feelings; traumatic aftereffects of separation and how to prevent them. A highly recommended, sensitive essay, essential for child care workers and supervisors.

Mandelbaum, Arthur. "Parent-Child Separation: Its Significance to Parents." Social Work 7 (October 1962): pp. 26-35.

This article gives workers some understanding of the feelings of both parents and children in placement. This empathy can direct workers in their intervention techniques in helping families through this difficult time.

Trieschman, Albert, and Levine, Bernard. "Helping Children Learn to Deal with Sadness." In Children Away from Home. Edited by James Whittaker and Albert Trieschman. Chicago: Aldine Publishing Co., 1972.

An excellent description of techniques child care workers can use in helping children through the grieving process. The basis of part of this module, this article is highly recommended.

HANDOUTS

SELF-ASSESSMENT: LOSS, SEPARATION, AND PLACEMENT

Use this form as a measure of what benefits you derive from training. Your trainer may also want to use it to help evaluate the training program. For both of these uses, you need to be as candid as possible.

Choose the number on the scale that most closely represents your level of activity for (a) and (b). Write the number in the appropriate box below. Answer "yes" or "no" to (c). Repeat this process once at three months and again at six months following training.

a. I make it a point to detect the phase of the grieving process that a child in placement is experiencing.

b. I design plans and use techniques for helping children work through the grieving process.

c. I am aware of my own reactions to losses in my life and of the bearing these reactions have on my professional role.

1	2	3	4	5	6	7	8	9	10
never	occasionally			sometimes			often		always

	a. Child's grieving process	b. Specific techniques for helping children	c. My own grieving process
1. Before training			
2. Three months after training			
3. Six months after training			

The goals of training are to increase your efforts to detect the phase of the children's grieving process, to help them through it, and to become more aware of the influence of how you respond to losses. If these goals are not accomplished, try to figure out why and share your reflections with the trainer.

THEORIES OF LOSS AND GRIEVING

Lindemann Bereavement: Symptoms of Normal Grief	Kubler-Ross Five Responses to Prospect of Dying	Bowlby/Thomas Responses to Separation	Common Pattern of Grief Process
Major Block: Denial	Denial	Preprotest, denial	Denial
Somatic Distress			
Preoccupation with Image of Deceased			
Anger	Anger, Resentment	Protest	Anger
Guilt	Bargaining		
Restlessness, Searching	Depression	Despair	Guilt, Despair
Working Through/Grief Work			Repetition, Coping
Emancipation from Bondage to Deceased			
Readjustment to Environment	Acceptance	Detachment	Adjustment
Formation of New Relationships			

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STAGES OF LOSS AND SEPARATION*

Phase	Effects	Behaviors
Preprotest	1. None or extremely shallow 2. If present, it appears minimal, in form of soberness or false happiness	1. Seems to reflect automatic social without emotional involvement 2. Generally conforming
Protest	1. Anxiety 2. Anger 3. Helplessness 4. Weeping	1. Thought and behavior directed toward lost object (person) 2. Anger is expressed toward the lost object (person), others in the environment, and the self 3. Appeal for help and rejection of the help 4. Active effort to obtain the lost object (person) and craving for it (person)
Despair	1. Pain 2. Depression 3. Despair 4. Hopelessness	1. Longing continues, but active efforts to obtain help are given up 2. Apathetic 3. Few demands on environment 4. Activity is disorganized, purposeless, restless 5. Lack of goal direction and little capacity to initiate activity 6. Withdrawal is pronounced, resulting in a lack of interchange with the external world 7. A preoccupation with things - not people 8. Regression marked
Detachment	1. Hope 2. Sense of mastery	1. Primary investment in lost person has been removed; some thought of the lost person, but it is based on reality 2. New relationships sought and emotional investment in them 3. Behavior reorganized, more purposeful 4. Reality testing

* Based on papers by John Bowlby and Carolyn Thomas

CASE HISTORY: JIM

Jim was born in the summer of 1966 to Mr. and Mrs. Willow. He lived at home with them. At age two, Jim was abused by his father. He beat Jim's hands until they were swollen, held Jim upside down in the tub, and submerged his head in water to the point of almost drowning him.

As a result, Jim was placed in the T's foster home and remained there until he was three. He was then returned home. At this point his father said that he would seek help for his problems. During this time at home, Jim began showing signs of emotional disturbance; he would become destructive and would smear feces on the walls. When Jim was 4½, his parents separated.

Jim was admitted to a state hospital and his mother moved out of state with another man, Mr. Cloud, when Jim was five.

Three months later, Jim returned to the T's foster home. While there, Jim showed continued signs of disturbance, wearing Mrs. T's underwear, defecating in closets, etc.

The next month, Mrs. Willow and Mr. Cloud returned to the state and county where Jim lived. At age six, Jim was placed in the G's foster home because Mrs. T had to care for her sick mother and felt that Jim would be too much for her.

Jim remained at the G's foster home until he was seven, when they asked for his removal. Thus, Jim returned to Mrs. Willow and Mr. Cloud who were willing to go to counseling sessions at the state hospital for help in dealing with their children. Jim began having problems in school. He was hyperactive and disruptive and stole things. At home, his behavior consisted of ripping clothes, breaking and throwing toys, defecating in the garage, and fighting with his siblings. At 7½, while the children were with a babysitter, Jim started a fire in the bedroom. Because Mrs. Willow and Mr. Cloud were unreachable at the time of the fire, all the children were placed in emergency foster care. Jim, however, because of his past, was placed back in the state hospital several days later.

Jim remained at the state hospital until he was eight years old, when he returned home. Mrs. Willow tried behavior modification approaches with Jim, but after little success with this, she reverted to harsh punishment. Also, at this time, Mrs. Willow divorced Mr. Willow and married Mr. Cloud.

In the fall of that year, the family was asked to move because Jim and his sister were setting fires. By winter, Jim's behavior in school seemed to improve, except that he sometimes masturbated. The school also reported that his behavior was worse after returning from a weekend or vacation at home. At home, rivalry between Jim and his sister became more intense; and playing with matches continued.

Just after Jim's ninth birthday, Mrs. Cloud began considering surrendering Jim, but Mr. Cloud was against it. During the fall, Mr. and Mrs. Cloud worked with the mental health clinic. They used structure and praise with Jim, which worked for a while, but then regression set in. Jim was spreading feces on the walls, killing small animals, and smearing blood around the house. Masturbation in school increased and he spent most of his time in the principal's office sitting and staring at objects for hours on end.

Things continued this way through the winter, when Mrs. Cloud became very concerned over Jim's increased sex play with his sister and his lifting of girls' skirts in school.

At age ten, Jim was admitted to a residential program.

The outstanding problem, as his parents described it, was his inability to feel close to them and to talk with them. Initial conference material saw him as a frozen child.

MAJOR EVENTS DURING JIM'S PLACEMENT

The following is a running history of major events covering fifteen months of Jim's placement.

1st Month:

1. Admitted to the residential program
2. Honeymooning

2nd Month

1. Visit with family at cottage
2. Periodic running out

3rd Month

No major events

4th Month

1. Second family visit at cottage

5th Month

1. First home visit
2. Weekend home visit at Thanksgiving

6th Month

1. Did not go home for Christmas. Parents thought Thanksgiving was enough and were overwhelmed by internal family problems.

7th Month

1. Day visit at home supervised by staff member

8th Month

1. Overnight visit at home supervised by staff member

9th Month

1. Running out started - out 4½ hours
2. Ran out ½ hour
3. Ran out 6 hours - in a dangerous stream with other kids who ran out with him

10th Month

1. Ran out
2. Home visit cancelled by parents because of Jim's running
3. Ran out - expressed negativism and fatalism regarding his feelings of ever going home
4. Called home - got message from family "if he ran out again they would not have anything to do with him"
5. Depressed during the day - choked himself with his hands - directed anger toward staff
6. Ran out - needed physical involvement upon return
7. Smell of match smoke in his room - no matches found
8. Ran out several times
9. Home visit with social worker - with social worker's involvement, the family came to the decision that they should visit more regularly, in spite of the increased negative behavior.
10. During the return trip with the social worker from the home visit, Jim expressed a lot of anger toward the social worker. He threatened to jump from the car and actually opened the door while the car was moving - he "wanted to jump out and run to his family." He didn't believe they would visit.
11. In the cottage, directed anger at peers and adults and provoked adult physical involvement
12. Unable to sleep well at night or function in routines during the day - very disorganized
13. One-to-one adult involvement provided, unable to tie in with his group

11th Month

1. Scheduled phone call home - day went well, no major problems
2. One-to-one attention provided most of the day - ran out for several hours anyway
3. Talked about his parents' changing their minds and that they wouldn't visit. Finally, got into how miserable his life was and that he was sure he would continue to make it that way
4. Talked about old people and death. Family changed date of last visit, were due today
5. Spacy - in his own world - not in routines - then ran out until night time
6. Tried to get peers to fight with him
7. Family missed scheduled last visit - Jim felt they would never come again - wandered rest of the day
8. Ran out alone on a cold and rainy night - called home collect from a pay phone - talked to father at 10 p.m. Found wandering on street at 2:30 a.m. by two women who returned him here
9. Ran out for several hours

10. Family visited at cottage; explained because of car trouble they missed last two visits. Schedule was planned for future regular visits
11. Ran out from 9 a.m. to 8:30 p.m. Wrote following note to staff: "I want to go home. I want to go home now. I want my family. Please can't I have my family?
12. One-to-one with staff for part of the day - attempted to run out
13. Totally at loose ends today - constantly needed supervision
14. Did not eat dinner - said he was on a diet
15. Began using tape recorder for fun issues
16. Family visit - gave Jim caring messages and told him they want him home. Told him he needs to learn to communicate with others, not follow other kids, and to know what he wants for himself. They would have him home for a visit on a specific date if his behavior improved. Several attempts to run out. Used tape recorder tonight - composed a song of hopelessness and longing for his family. Told a story he said his mom told him, about a child being kidnapped and hung in a restroom at a school
17. Complaints of being sick - guitar lessons arranged for him
18. Ran out 5 p.m. - 9 p.m. Tried to hit an adult with a stick
19. Ran out with other kids - "I don't care" responses to everything - OK evening
20. Ran out 8 a.m. to 9:30 p.m. with another child. Arranged with family that Jim call home one time per week if he asks to do this
21. Hit adult in charge in a kidding manner, yet tried to latch onto the adult
22. Isolated himself in his room during the day
23. In his own fantasy world during a trip to a playland - hard time returning to reality to leave to go back to cottage
24. Ran out
25. Needed one-to-one attention from adults. Sought negative interactions from peers
26. A lot of physical complaints. Asked a staff member to adopt him

12th Month

1. Day visit at home supervised by staff
2. Composed a song about his family, refused food
3. Received letter from his family stating all was well at home
    a) You have so many problems
    b) You have to change your behavior before you can come home for good
    c) We want you home

    He responded by only reading part of it
4. Locked himself in staff office, tried to call home
5. Called home, very upset. Locked himself in a room with another child

6. Cleaned out bird cage - said he wants to be locked in a cage
7. Stole cigarettes
8. Ran out for 1½ hours
9. Stole food and cigarettes, wandered
10. Spoke of family and found out maternal grandfather died. Cried at bedtime saying "I will never be happy. Why did this have to happen to me? I only want my family. Nobody knows what I'm going through." Told staff he felt these things happened to him because he was bad and that he didn't want staff to care for him
11. His birthday; acted depressed and wandered. Told of a dream - he had gone home on a visit; upon returning, he wrote a letter to his family but they never got it
12. Ran on grounds with a friend all evening
13. Home for weekend visit unsupervised
14. Helped build a go-cart, able to resist approaches to run by peer. Responded to adult directions to not allow himself to be set up - didn't run
15. Attended agency open house; many families were present including his own
16. Wrote letter to his family saying he wanted to see them more often
17. Depressed, ran out. Upon his return, he said he did not care about anything. He said he was like his natural father, and that he was going to commit suicide and be buried in his grandfather's tomb

13th Month

1. Weekend home visit. Mom said he is doing very well
2. Ran out. Talked of hurting himself
3. Wrote a letter to kids that run, saying he was not going to do this anymore because he wanted to go home
4. Stole food, ran
5. Showed concern over his appearance
6. Angry over staff taking vacations; interest in starting a diet
7. Social workers talked to him about his improved behavior
8. Called home - negative all day
9. Wrote letter to family asking for a visit - told staff they wanted to keep him away from his family
10. Reread family's old letter
11. Upset over his teacher's vacation. Staff felt that he is tying into them
12. Home visit

14th Month

1. Said he had three wishes:
    a) to go home
    b) to live a good life
    c) to live in a good neighborhood
2. Attended a community day camp for two weeks, general improvement of behavior in cottage
3. Feeling ambivalent about returning home
4. Violent attacks on peers

15th Month

1. Home visit
2. Ran out
3. Wrote letter telling staff how alone he felt
4. Team meeting in regard to discharge planning, child and family present
5. Started diet
6. Ran out
7. Told peers about discharge date. He asked staff if they were planning a going away party for him. Found crying in his room

Worksheet for Assessing Stages of Grieving

MONTH NUMBER: ________________

Event	Stage Represented	Plan or method of dealing with the feelings
Example: Running out of cottage	Protest	Acknowledge child's anger, give nurturance

ACTIVITIES OF HELP IN DEALING WITH LOSS AND SEPARATION

1. Pet care
2. Using tape recorder - choice of sharing tape with adult
3. Music lessons - avenue to express feelings
4. Scrapbook on past, present, hopes for the future
5. Life tree (Who am I?)
6. Providing a legitimate hiding place
7. 1:1 attention
8. Behavior modification program based on completion of routines
9. Writing letters or keeping a diary
10. Taking child to grave of important person
11. Scheduling phone calls to family, frequency decreasing or increasing
12. Writing letter to parents discussing issues of surrender/placement
13. Drawing pictures
14. Play-therapy puppets, dollhouse, play guns, play telephone
15. Group therapy - discussions on family and staff losses, death
16. Drama, puppet shows, projective stories with loss as theme
17. Finding homes for pets
18. Clubs - rockets, health, models, sports
19. Contact with past significant people
    a) to terminate
    b) to stimulate feelings
20. Team meetings with child and family, including them in treatment
21. Use of fairy tales and stories - Wizard of Oz, Hansel and Gretel, Charlotte's Web

22. Child's dreams - interpretation
23. Games (hide and go seek)
24. Contracting with child and family about specific goals
25. Group activity: "running away"
26. Television programs with family themes - The Waltons, Little House on the Prairie
27. Keeping an address book
28. Writing a story or play
29. Making a comic book
30. Art therapy - clay, woodworking
31. Target practice (squirt gun, snowballs, archery)

TREATMENT IMPLICATIONS FOR STAFF

Task of worker is to help child and family deal with loss, help child go through grieving process.

SOME GUIDELINES:

1. Help overcome denial - acknowledge loss, share pain, etc.
2. Help verbalize - help express unexpressed thoughts, label feelings.
3. Move at speed of child - give help geared to stage of grief.
4. Recognize need to work through loss over and over.
5. Handle with consistency, respect, nurturance - help child redefine self.
6. Reject rejection - resist child's efforts to fend you off by manipulating you into rejecting him.
7. Recognize the dynamics of loss operative in other separation situations, e.g., staff member leaving, change of cottage, termination of placement, etc.
8. Design programming, cottage procedures, etc., to address specific needs of child in separation.

Remember: Child needs to face fact of loss but requires support while doing so.

This is critical if he is to be able to accept any kind of permanent relationship in the future.

The most concrete examples of a child experiencing separation and loss are:

1) Child's entering care (e.g., residential, foster care, adoptive home, etc.).

2) Child's leaving to return to permanent plan (e.g., natural home, independent living, adoptive home, etc.).

3) Child's transition between visiting resource and placement.

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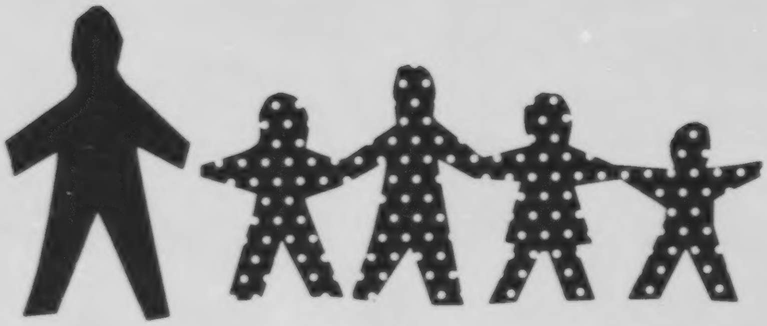

Children, Families, and Child Care Workers

by Patricia O'Donnell, Patricia Perfetto, and Wayne Ouderkirk

INTRODUCTION

Children who come into residential care usually have lived in a family setting for part of their lives. In some cases these children have lived with more than one family. What impact does the family have on the child? What memories, values, behaviors, and attitudes are associated with the family? In order for a child care worker to relate to the total child, he or she needs an understanding of the child's family system and background. Records and observations made by other professionals are helpful, but what better experience is there than first-hand knowledge?

One of the main goals of treatment is to return the child to a permanent community-based setting, preferably to a family setting, as soon as possible. Children grow and develop better when they are living with their family in the mainstream of society. It is the child care worker's task to bridge the gap for these children between institutional living and family life. The distance is too large unless efforts are made to involve the child and his family in both environments, so that neither system closes up and excludes the other. Thus, child care workers have a role in the treatment of the total family system, not just in the treatment of the family member in placement.

The purpose of this module is to present training materials that will aid the trainer in exploring with child care workers the significance of families for children, family dysfunction, and the role of the child care worker regarding families. The hope is that the better child care workers understand families of children in placement, the better equipped they will be to develop a helping relationship with the whole family system.

BEHAVIORAL OBJECTIVES

After participating in this training session, workers will

1. Be more likely to agree that families are important to chilren's treatment processes.
2. Be able to list and explain the dynamics found in the World of Abnormal Rearing (WAR) cycle.
3. Be able to identify behavior patterns that relate to specific WAR cycle dynamics.
4. Be more likely to agree that child care workers have a role in working with children's families.
5. Be able to identify five child care worker's interventions in response to WAR cycle families' needs.

BEHAVIORAL CHANGES

1. In team meetings, child care workers will show a clearer understanding of a family's importance to a child and the family dynamics involved in the case.

2. Child care workers will show a desire for more child-family contact in appropriate cases.

3. Child care workers will interact with social workers regarding involvement with children's families and the family dynamics of the case.

4. Workers will consciously utilize contacts they have with family members in positive ways and will seek out further contacts.

RESOURCE PAPER: DEALING WITH DYSFUNCTIONAL FAMILIES*

The two major points of this paper - and of the module as a whole - are to present a theoretical framework that child care workers can use to better understand the families of the children with whom they work and to explain what it is that child care workers might do within the child care role to help reunite the child and family. The first of these two points is not in itself unusual; but within the present context of child care, the second point is unusual, if not startling.

In part one of the paper, a theory about the way many families experience extreme problems is presented. This part of the paper constitutes the first part of the argument in favor of child care workers dealing with families. Since there has in the past been very little contact between child care workers and families (especially parents), and since child care workers often develop hostility toward parents, the claim that such workers have a professional role with those parents needs to be discussed. This issue is treated in the second part of the paper and a training activity devoted to it is included in the appropriate session.

Part I: Family Dysfunction

What is family dysfunction? Quite simply, a family is dysfunctional when it does not meet the individual needs for nurturance, growth, and development of any one or more of its members. Some more visible signs of this are conflicts with other systems and the breakdown of relationships.

There are a number of theories dealing with the causes or dynamics of abuse, neglect, juvenile delinquency, and other social problems involving families. These theories provide different ways of viewing interrelated problems. Each theory tries to simplify the complexities of family interaction in order to develop a general framework from which to view families and make sense of what can happen with them.

There are several advantages of knowing and using the frameworks provided by such theories. First, we come to know general human dynamics, which helps us in assessing individual cases. In addition, the understanding of these dynamics increases our empathy for the children and their families. Finally, this understanding helps us choose appropriate interventions. Like other human services professionals, child care workers need to use theory to draw conclusions about individual cases. They also need to use experiences from their practice to develop theories that aid in organizing their field.

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* We are indebted to Mary Ellen Deighan for her work on earlier versions of this paper and training session.

151

For purposes of this training paper, we will use Kempe and Helfer's World of Abnormal Rearing (WAR) cycle.[1] It shows how children who experience a variety of negative events or deprivations in childhood grow up to perpetuate an endless cycle of family dysfunction. Although the theory was developed to explain child abuse and neglect, it is applicable to many of the cases that we work with in child care agencies. However, it must be stressed that not all of the families of children in residential care have developed in the manner presented here, nor are all such families so weak and disorganized. The purpose of this theory is to provide an initial picture of family dysfunction, which child care workers can begin to use in understanding and assessing families.*

As you can see by the diagram on page 198, we have sectioned the WAR cycle into five areas: nurturance and trust, expectations and controls, social relationships and self-esteem, spouse support, and parents' perception of child.

For purposes of illustration, we will talk about some extreme situations. In our work, of course, we are involved in a whole range of situations, never as clear-cut as these. Examples of the dynamics are given as they appear in child care situations. Later, in part two, examples will be given of appropriate child care interventions with both children and families.

Nurturance and Trust

The cycle starts with the parent as an infant in the nurturance and trust stage. It is important to remember that we are looking at the parent as a child. An infant is totally dependent on a parent or parent substitute for having basic needs met. These needs are common to all of us and are of two general but essential kinds:

1. Physical - the need for food, warmth, dryness, and so on.
2. Interpersonal - the need for being loved and valued. How well this need is met depends on the care and consistency with which physical needs are met.

A key concept in this section of the WAR cycle, and of course in Erikson's theory of human development, is the concept of trust or mistrust. The capacity to nurture a small child is acquired through the experiences of being loved and cared for during one's own childhood. This concept is called the mothering imprint. The optimal time for imprinting is said to be between the ages of birth and twelve to fifteen months. As infants and children, WAR cycle parents did not have their own needs met consistently, nor did they have nurturing relationships with their parents. Thus they acquired neither a positive mothering imprint nor a sense of trust. As a result, their own dependency needs are still so overwhelming that they are unable to perceive or meet the needs of their own children.

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* For a presentation which depicts typical developmental milestones of a family along with associated stresses and resolutions, see Sonya L. Rhodes, "A Developmental Approach to the Life Cycle of the Family," Social Casework 58, no. 5 (May 1977): pp. 301-311.

What happens to WAR cycle children? Instead of developing trust, they develop mistrust. This mistrust is displayed in many different ways. A child who is mistrusting might experience depression, anxiety, anger, and hostility. Since these "negative feelings" are not acceptable to most WAR cycle parents, the child generally learns to repress them, and they come out in other ways. For example, a WAR cycle child who has repressed her anger might live with such rage at her early deprivations that she responds to her own child's demands (crying, whining) with aggression. If as a child her needs were responded to by attack, her own child's demands will stir up these old hurts. The pain must be stopped; she lashes out at the child. In this context, child abuse acquires its own horrible logic.

On the other end of the abuse continuum we see neglectful parents. Instead of allowing themselves to express their "awful" feelings, these neglectful parents repress feelings totally; they go numb. Numbness is a buffer between them and everything else; it is a detachment, a holding back. It allows them to escape the danger of being hurt or hurting somebody. It is safe but lonely--there is no pain, there is no pleasure. With these parents we see an overwhelming sense of futility, and they respond to their children with apathy.

In child care we have all seen the child and his family who come to us never having experienced a trusting relationship. For example, one child might stuff himself beyond capacity at each meal, for he doesn't trust that he will get enough to eat. Another child steals cookies right before snack time because he doesn't believe he'll get them. A family may believe whatever fables the child tells about the horrendous things the child care workers do to him, since neither they nor their child can trust anything else to happen.

Expectations and Controls

We now enter the second stage of the WAR cycle, expectations and controls. In normal parenting, the parents' role is to meet the needs of the child. Generally, but not always, we put the child's needs first. As a parent, we get pleasure from this; we get gratification from performing routine physical tasks for the child and from giving to a child emotionally. We set up expectations and controls for a child because of his needs, not our own.

Because the dependency needs of WAR cycle parents have been unmet, their own needs take precedence, and their interactions with the child are directed toward satisfying these needs. This leads to unrealistic expectations of the child. These parents are totally unaware of normal child behavior and development. For example, the facts that infants cry, spit up, and wet and that toddlers are messy eaters, get into everything, say "No," and are not toilet trained at age one are taken by such parents as signs of disobedience rather than as what they actually are. Such stresses of caring for a child are great enough for "average" parents, but they become almost impossible for WAR cycle parents.

Some families have such high expectations that there is no way a child could meet them. WAR cycle parents may expect a child to be warm, loving, neat, obedient, and considerate of their needs. Thus, the child can never measure up, no matter how hard he tries. He can never do the right thing and is constantly being chastised, belittled, neglected, or often physically abused.

What happens to the children? Generally, children strive, often desperately, to comply. This can lead to the situation where parental and child roles are reversed. The child assumes the task of trying to take care of the parents. It can be confusing when we see a child, who seems to be such a good, loving, considerate kid. But going back to normal child development patterns, it becomes clear that the child is not acting his age, but is presenting a pseudomaturity, being the "little adult." These children pay a price by missing childhood. If they are successful in complying with expectations, they show a false maturity; normal developmental experiences of childhood are missed. When they grow up, there's a noticeable lack of joy in life.

We have all known a child in care who seems to be on a continuous honeymoon. Anything we ask he does, to the point where we wish just once that he would throw a temper tantrum and say "No." We have also experienced the child who can take over the whole group of kids, should the adult get ill or otherwise occupied. While the worker is involved in restraining another child, the self-appointed junior counselor swings into action!

Another aspect of this stage are the controls that parents provide for the child. With WAR cycle parents, the controls are often out of whack. For example, abusive parents, because of their rage, often punish the child out of proportion to his behavior. When the child's needs conflict with their own, we often see very rigid controls. Neglectful parents, because of their numbness, show an absence of control. The children must fend for themselves. These parents abdicate their parenting role. In between, there is a whole range of inconsistent controls, sometimes rigid, sometimes absent, sometimes appropriate.

Generally, WAR cycle children are deficient in areas of control when they grow up. We probably all know parents of children at our agencies, who are what Polansky calls "impulse ridden"[2] - the restless, rebellious, defiant, unstable people who function well for a time and then "take off" when they cannot tolerate stress or frustration any longer. We also see impulsive children. Many were placed because of impulsive behavior. ("Why did you steal that car?" Reply: "I don't know. It was just fun at that time. Everybody else was doing it.") These and children placed for other reasons cannot at first accept the controls we give them in our units. Placed in the context of the WAR cycle, their inability to do so appears in a different light: they were given inappropriate controls before they came to us, and many of them cannot trust the world to give them what they need. Their parents, who often get the blame for this, are handicapped by the same dynamics. Is it any wonder, then, that they come into conflicts that bring them to us?

Controls are learned, not inborn. Initially, controls come from the parents. Then the child is able to control himself in order to avoid punishment. Later, he controls himself to keep his parents' love. Still later, he controls himself to please himself: "I can do it!" Finally, at the last stage, controls are internalized, they become a habit. (This sequence correlates with Erikson's developmental stages.) To learn control a child needs both love (without love why would a child bother to please his parents?) and consistent limits (to know what to internalize). Inconsistent limits cause confusion and spotty control. If limits are too rigid, there's no need to internalize; a child can rely on outside controls, or internalize rigidity, or rebel totally against limits. We've all seen children of these types.

Social Relationships and Self-Esteem

As the parent grows older - we are still considering the parent's development - he or she experiences the next phase of the WAR cycle, social relationships and self-esteem. The ability to turn to others for support or help is an important skill in coping with life. The average person has learned to trust others - family, friends, co-workers - but WAR cycle children have not. They have learned that they have to depend on themselves: they cannot ask for help, and they cannot accept help. If they do ask, it often is in a hostile, demanding way.

As adults, they become isolated, with no lifelines, no close friends or social life. They are isolated by frequent moves. Their contacts with parents or neighbors are seldom successful. They expect rejection from others, including us. Their inability to use others well also leads to an inability to help others, which reinforces an already poor self-image: "I'm no good." A good self-concept comes from feeling loved and valued and from feeling competent in life experience, having a sense of accomplishment. An average person feels okay about himself. He likes praise, but is not devastated if he does not get it.

He can praise others. He does not fall apart if criticized. He can handle criticism in a number of ways: ignore it, cancel it out as inaccurate, or try to change himself by accepting it. In any case, if criticized by someone, he does not feel that everyone is picking on him. As a parent, he expects a child will at times get angry with him.

In contrast, WAR cycle children do not feel loved or valued. Because of unrealistic expectations, they feel incompetent and have poor self-esteem. As adults, they have no cushion of self-esteem to carry them through periods of stress. They need constant reassurance and approval. They are shattered by criticism, real or imagined. They turn to their children for reassurance, so they are especially vulnerable. When their baby cries, it becomes a reflection on them! "I'm an inadequate mother." The lower the self-esteem, the higher the potential for abuse.

In working with children in residence, we have encountered the child who will not try anything new. He is so fearful of failing that he will not even bother trying. We have also experienced the child who, upon completion of a project, immediately destroys it. He cannot risk displaying his work; he feels it is not good, and that others will reinforce that feeling. And then there are the children who have major blowups over the slightest criticism by others.

As we know, poor self-esteem leads to isolation and an inability to ask for help. In Trieschman's article on temper tantrums,[3] we see how children cannot directly appeal for help, but instead give us lots of clues by "rumbling and grumbling." Trieschman even calls the second stage of a temper tantrum the "help-help" stage. Again, this points out that the child cannot ask for help in the usual way.

Spouse Support

A fourth area in the WAR cycle is spouse support - or, more accurately, lack of it. WAR cycle families are not only isolated from people outside the family, but from one another as well. Because of unmet dependency needs, lack of trust, and poor self-esteem, WAR children have not developed good skills in selecting friends. This hinders their ability to select a mate. Because of their negative experience in childhood, they are often in a hurry to leave home and select a mate. They want to find someone to meet their needs. Spouses are often, therefore, unhelpful and unsupportive, like themselves. Of course this is not evident to them in the courting process.

In average families, spouses provide support in child rearing in several important ways: they provide emotional support with day-to-day difficulties in child rearing, they can listen to and discuss problems, and they provide relief from actual tasks--changing diapers, feeding, discipline.

In WAR cycle families, instead of sharing there is competition. For example, whose needs are going to be met? Both spouses are desperate to get and unable to give. Because of poor self-esteem and vulnerability, they cannot even ask outright for what they want from each other. Often there is dissatisfaction, conflict, abandonment, or staying together unhappily--clinging to each other but emotionally divorced. The distance protects them from being hurt, but also keeps away any chance of support. Again, there is no healthy escape when there are problems.

When we work with children we see their inability to select friends. The younger children choose to play with peers that have similar difficulties, and adolescents tend to date others with similar problems.

Perception of the Child

Since their mates are of little help, the question arises: Where do these parents turn? Answer: Have a baby! We are into the fifth phase, the WAR cycle parents' perception of the child. In a WAR cycle situation, a baby can be perceived as a solution to at least some problems. The child might get them out of an unhappy home, or give them status, or be great for their self-esteem by proving to their parents, mates, and themselves that they can be good parents. The hope of giving their child a better life than they had builds their self-esteem. The child will also be someone to keep them company and in time to take care of them.

Thus, conception becomes a major goal. Most WAR cycle children are wanted, but generally for the wrong reasons. Wanted pregnancies often produce unwanted children. Pregnancy itself may become unwanted, especially if there are problems. Then the child is born and he is not at all what was expected. Instead of sleeping sixteen hours and smiling the rest of the time, he cries and fusses and wets and spits up. WAR parents experience stress instead of comfort.

An average parent views a child as a person in his own right. WAR cycle parents have a distorted view. The child is seen as different from what they had hoped. The parent may have a distorted belief about how the child views the parent and may attribute motivation to the child; for example, crying is seen as a way to upset the parents. The child may be perceived by the parent as being like someone else, for example, the disliked mate or the parent himself as a child (who therefore should be treated as he was treated). In some psychotic cases, the image of the child may be fused with the parent's image, so that when the parent wants to punish himself, he punishes the child. Whether perceived as separate or not, the child is born into an impossible situation. He or she is expected to meet the needs of the parents. The WAR cycle begins anew with the children we care for in residential placement.

These children may themselves perpetuate the cycle. Anyone who has worked long enough with children has seen teenagers actually go through this process. They believe that the only one who cares for them is the mate they have selected--who has the same kinds of problems! They leave the agency, get pregnant, and come back to show off their babies to their friends, who admire them and the babies.

Summary

What is evident is that there is a significant gap in the developmental process. WAR cycle children spend so much time trying to meet the needs of their parents that they forfeit large segments of normal childhood.

As adults, they have tremendous conflicts between unmet dependency needs and their lack of trust. Their lack of joy is perhaps the most noticeable characteristic, and inability to cope with stress is one of their greatest handicaps. Obviously, WAR cycle families are not all identical; there are as many variations on these themes as there are people involved.

Part II: The Child Care Role with Families

For the child care worker, the uses of the WAR cycle framework are many. Understanding a child's family background assists in developing appropriate plans for the child, in understanding problem behaviors, and in devising specific interventions. But why should the child care worker play a role with the family or parents of the child? Isn't that the province of the social worker? Don't child care workers have enough to do already? These are appropriate questions. The attempt to answer them will be made from a consideration of three separate, but related, perspectives: the child's needs, current practice and standards of care in New York State, and the skills of professional child care workers. After that, some of the problems arising from dealing with families will be discussed.

Before treating any of these issues, one essential point must be made: when we advocate that families and their children in care have more contact, that families visit more frequently and become involved in the cottage setting, we do not intend this to mean all families. There are situations where the courts have limited such contact. There are other cases in which the whole treatment team must raise the question: "Is it possible and realistic to reunite this child with the natural (or adopted) family?" The answer must be arrived at carefully. What we advocate in this paper is to involve extensively families who can be a resource for their child, who are able and willing to participate and use the total helping process for their own and their child's well-being.

The Child's Needs

The traumatic effects on a child of separation from family are well documented.[4] Such separations begin a real and necessary grieving process that the child must negotiate. In the past, and in some cases in the present, child caring agencies have aggravated or impeded this process. Policies that unnecessarily restrict the amount of visiting between children and families, that limit the areas of visiting ("No families in the children's living area"), that limit the amount of other contacts (phone calls, home visits, etc.), all add to the difficulty of separation for the child and the family.

Whether intentional or not, the effect of those and other policies is to communicate to the child a sense that the family is being rejected, even when the verbal message to everyone is that the family is very important to the whole process of care. The family receives a similar unspoken message: "You are not wanted here, you cannot help your child." It is no wonder that many families gradually stop visiting the child in care. For the child, the cumulative effect is simply an even greater loss.

Because so many - clearly not all - of the families of children in care can be characterized in WAR cycle terms, it may seem to some that such messages are indeed appropriate. Child care workers often become very protective of children with whom they work. Part of that protectiveness takes the form of hostility toward parents and/or families. Explicit or not, this attitude gets communicated to the child. The child then perceives that the two care-giving forces in his life do not trust one another. Estrangement, confusion, guilt, hostility - how else can a child react than with a host of negative feelings toward the worker, the parent, the agency, or all three.

Yet, both the child care worker and the child care agency have a professional commitment to help the child return to the community at large. Whatever other problems the child and worker must overcome, the issues caused by loss are formidable. If the gulf between child and family is widened in the ways already described, the ability of the child to return to the large community is significantly impaired. That family *is* that child's family, that child's link to his past and future, that child's source of identity. No matter what we think, there is an unbreakable link between the family and the child.

Simply put, the child *needs* the family. A family is a basic human requirement. If our efforts at rehabilitating the child are to have any prospect of long-term success, we must involve the family and maintain the child-family relationship. This does *not* mean that the child care worker becomes a family therapist; this *is* the job of the agency social worker, and it is necessary and helpful in many cases. But only the child care worker can provide the context for frequent involvement of the family with the child throughout the term of placement.* With an understanding of the family background and an agreement to work together, the distance between workers and parents can be reduced, and separation can be less of an issue for the child. Everyone concerned - child, parent, child care worker - can go on to grapple with the problems that actually caused the child's placement, rather than with one effect of that placement.

Recent studies of parental contact with children have lent increased weight to this effort of involving parents more closely in the child's placement. David Fanshel, in a five-year longitudinal study of 624 children in a foster care system in New York City, found significant relationships between the amount of parental visiting, the length of time a child remains in foster care, and discharge patterns.[5] Very briefly, the findings were these: (1) A much higher number of those children whose parents visit them frequently are discharged than of those whose parents visit infrequently or not at all. (2) A much higher number of those who are visited frequently early in their placement are discharged sooner than those not visited. "Sixty-six percent of the children whose parents engaged in no visiting (at the beginning of the study) were still in foster care five years after their entry," compared with 31 percent and 27 percent of those whose parents visited frequently or as much as permitted.[6]

From these and other statistical analyses, Fanshel points out, "The strength of the relationship between visiting and discharge is impressive and demonstrates the centrality of visiting as a key element in the return of foster children to their own homes."[7] While it is true that Fanshel's study focused on foster care in general, rather than on child care agencies, the results are significant. They indicate that closing the gap between the child in care and the parent will greatly help in achieving the main goal of placement: the return of the child to his or her home.[8]

Although critics may agree that increased visiting is beneficial, they maintain that this still does not mean that the child care worker should deal with the parent. However, as indicated above, it is the child care setting that provides the best context for such involvement. Visiting, without some activity, becomes empty and boring. This will be discussed below.

Current Standards and Practice

In 1976 the New York State Legislature recognized the needs of the child to remain with his or her family. At the beginning of the permanency law, it is stated:

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* See p. 162 for a discussion of the agency's part in this.

> (i) it is desirable for children to grow up with a normal family life in a permanent home and that such circumstance offers the best opportunity for children to develop and thrive;
>
> (ii) it is generally desirable for the child to remain with or be returned to the natural parent because the child's need for a normal family life will usually best be met in the natural home, and that the parents are entitled to bring up their own children unless the best interests of the child would be thereby endangered.
>
> (iii) the state's first obligation is to help the family with services to prevent its breakup or to reunite it if the child has already left home.
>
> (New York State Social Services Law, Section 384-b)

This statement is an eloquent testimonial to the state's commitment to maintain family unity whenever possible.

This concern has been codified by the New York State Department of Social Services, in the form of standards that must be followed in any situation in which the child must be removed from the home, including residential placement. In addition to defining goals and directions for service plans,[9] the Uniform Case Recording Standards Casework Manual states that "continued and frequent parent-child visitation is vital to the maintenance of family relationships and is an essential part of the overall planning" in foster care cases.[10] This case recording format requires that the visitation plan be completed within thirty days of placement. Of course, "frequent" is undefined and hence vague. But it cannot be denied that the intent of the regulation is to ensure that children and families are not permanently separated by the placement of the child.

Thus, it is clear that the specific policy of New York State regarding children in care is, from both a legal and administrative point of view, to encourage the reunion of children and families through increased contacts between them while the child is in care. This increased emphasis on families is reflected in new and exciting practices on the part of several child caring agencies. These practices are reflected in the child care literature.[11] Agencies have involved families within the child care unit and have also sent child care workers on home visits with the child. These efforts have all been aimed at bridging the gaps between the child's home and the agency, between the family and the child, and between the family and those who work with the child.

The child's needs for continued contact with the family and the standards and practices mentioned here do not necessarily indicate it is the child care worker's responsibility to work with parents. What, then, would indicate this?

Skills of Professional Child Care Workers

In general, child care workers' expertise involves the conscious use of parenting skills. Of course, other skills are also involved, e.g., teaching skills, communication skills, assessment skills, and so on. But for our purpose we will focus on those skills that can be grouped under parenting skills. Before discussing these skills, we have to say that such workers are clearly not parents to the children in residential care. However, many of the things they do are parental in nature. Here is a brief look at some of them.

1. Developing the capacity to trust. We know that many children come to us without a positive resolution of the first of Erikson's development crises, trust vs. mistrust. By providing such children with consistent nurturing care and with an accumulation of positive experiences, the worker helps the child learn to trust in much the same way as in normal child rearing.

2. Setting appropriate limits. Occasionally, workers feel like they are constantly setting limits! This involves putting controls on the child's behavior that help the child learn to interact with his or her environment--peers, adults, and physical surroundings--in a healthy way.

3. Teaching appropriate behaviors. This includes a whole range of things, from basic living skills to how to give and receive affection. It is actually the positive aspect of setting limits. Limits say "Do!" to a child, teaching says "Here's how."

4. Developing self-esteem. It is almost tiresome, but nonetheless important, to point out that child care workers help children to develop self-esteem. Again, it is something workers do in a myriad of ways, most of which involve providing opportunities for a child to succeed, based on a close knowledge of that child's skills and abilities.

5. Providing emotional support. When children cannot trust, they cannot take advantage of the supports that exist for them. This child care skill involves both the teaching and modeling of how to express feelings appropriately and support for such expression.

Of course, this is only one of the many ways we can consider child care skills. It is not an accident, however, that these skills parallel the difficulties experienced by children growing up in WAR cycle families. We have focused on these skills to provide the necessary link between parents and child care workers. The child care worker is the professional who possesses the parenting skills so desperately needed by WAR cycle parents. Neither social worker nor therapist has the day-to-day practice in using parenting skills with the children in care.

If we want a complete picture of the services needed to reunite children and family permanently, then we must include an opportunity for the parents to learn how to parent their children. No one within the child caring agency except the child care worker possesses those skills, plus the unique knowledge of the child in question, plus the knowledge of how to use those skills with that child.

It is not the purpose of this paper to discuss the social worker's role with families. But this much is clear: parenting skills are not a part of that role; they are part of the child care worker's role. This does not encroach upon the social worker's role or add to that of the child care worker. It fills a significant gap in the system of care in a way that answers the child's need for contact with the family, conforms to current standards of care, and takes advantage of the best of current practice.

How is it that the child care worker can properly intervene with parents? The best way to answer this question is to provide examples, parallel to the earlier descriptions of the skills:

1. Developing the capacity to trust. The more consistent is the care the child receives from us, the more he views us as dependable, trustworthy people. Similarly it is important for workers to have the maximum possible contact with parents. Only through contact can we demonstrate that we are trustworthy. By inviting a family into our cottage setting on a regular basis to observe the cottage program, we can give them the opportunity to overcome their mistrust of us. This will make the unknown known and demonstrate in action the agency's and worker's acceptance of the parents' importance in the child's life.

2. Setting appropriate limits. Quite simply, the worker can be a role model for the parents by stopping a child's inappropriate behaviors in a way that is clear and helpful to the child. When the parents are present, the child care worker can point out the child's behavior that needs limiting and show how limits are set when this behavior occurs. Both the behavior and the controls can then be discussed with the parents.

3. Teaching appropriate behaviors. Knowing what the child is trying to accomplish through negative behavior, the worker teaches appropriate ways to do the same thing. Again, the worker can model this teaching for a parent and then discuss the teaching afterward. Incorporated into this and the previous example is the worker's sharing with the parent new ways to interact with the child. The worker might accompany the child on a home visit to model proper parenting roles, for example, sharing a picture book with the child.

4. Developing self-esteem. Workers constantly strive to build up the fragile egos of the children, giving them "strokes" for all positive accomplishment and helping them recognize their strengths. The same techniques can be used to build the self-esteem of the parents. Each contact with parents can be used to reinforce that they are good. If a parent has a skill that could be shared with the group of children, that sharing could be worked into the unit's activity program. Or, with appropriate planning, the parent could help with a group outing.

5. Providing emotional support. Workers provide emotional support for children and adolescents in care. Once again, the skill can be modeled. In addition, the worker can become a source of emotional support for the parent. This is accomplished by communicating to the parent that the professionals also get upset, angry, or frustrated because of the child's problem behavior. This tells the parent that he or she is not alone in feeling overwhelmed and demonstrates one way of reaching out for help. The worker should not only express the feelings accurately, but should also say what he or she does about them (e.g., ask for help, take a walk, etc.).

Obviously, these examples do not exhaust the possibilities. They are only intended to illustrate how child care workers can work with parents and not step out of the role of child care worker.

Other Issues

By now the reader has a list, probably a lengthy one, of problems raised by this discussion. A convenient way to discuss these issues is to divide them into separate areas for attention.

1. The agency. Having child care workers work with families requires an extensive commitment on the part of the agency. Agencies are increasingly interested in family involvement, based on the successes other agencies have experienced* and on the increased awareness of the needs of the children in care, exhibited on the level of both practice and state policy.

   Workers who are interested in developing such a program need to make proposals, give reasons, and so on, just as they would for any major change in programs. The present discussion of problems that can arise will provide some insight for this sort of proposal. A good starting point, however, is for such workers to begin to exploit contacts they have - or could have - with parents within the existing agency structure: meeting and talking with parents on visiting days, chatting on the phone with them when they call their children, talking before and after meetings, having a cup of coffee with them when they pick up their children for home visits. Using these contacts to establish positive relationships *is* working with the parents. The more such experience *a* child care worker has, the better he or she can envision, propose, and carry out a program of involving parents in the unit.

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* A case in point is Parson's Child and Family Center of Albany, New York.

Workers should open and keep open the lines of communication with other team members, especially social workers. The more communication there is, the more interaction and support there will be. Thus, from these brief comments, workers can begin to see that parental involvement is feasible for them and their agencies, even without making radical program changes. Opportunities already exist for beginning work; the eventual outcome can be tailor-made to the particular agency, but the work can begin now.

2. *Worker and team.* Obviously, a worker who is not interested in dealing with families or who has had little experience in child care cannot be expected to be involved with families. If such involvement requires a strong agency commitment, it requires a still greater commitment on the part of the worker. In addition to commitment, the worker must have the skills that are supposed to be taught to the parent.

The experienced and willing child care worker must be paired with an experienced and equally willing social worker. While the child care work with families does not encroach on social work, the two disciplines border and must interact extensively at the family level. The child care worker must therefore be willing to cooperate and collaborate with the social worker. It is equally essential that the social worker view the child care worker as an equal partner with a unique contribution to make. As evidence of this view, the social worker will have to make changes, such as being available during the time that the parents will be in the cottage. In most cases this will be at hours when the social worker is not customarily on the grounds.

These two essential professionals--the child care worker and the social worker--need to be complemented by a supervisor who is able to help coordinate their efforts and to sort out and help resolve issues that arise. Included are such initial issues as who should deal with which problems and in what way must they be resolved, as well as such later issues as what the child care worker does when a parent begins talking about a marital problem during a child's home visit.

The rest of the treatment team must also support involvement with families. They must share information and cooperate with one another. Basic support of this kind will provide the full range of helping service that is essential to the successful reunification and strengthening of the family. One of the jobs of the whole team is to decide how to select appropriate families for this work.

3. The family: parents and child. What families are appropriate for this kind of program? The specific criteria must be worked out by the team in accordance with the agency and its type of client. But a general and obvious guideline will be offered here: any family that is willing to become involved to the extent required should be given the opportunity to do so. Such willingness will not always be evident. Parents and child will have to trust the agency and its members and to believe that they (parents and child) can change.

   Once the family and team decide to begin such work, the social worker, the child care worker, the supervisor, and the family - including the child - must agree in a "contracting" meeting on the specific goals to be worked on, by and with whom, and where. This is where the child care worker's skills begin to be applied. The purposes of the parent's visits to the cottage or of the worker's visits to the home are spelled out here and agreed upon by all.

   It must not be assumed that a family of this type will be rare, given the background of children in residential care. Recall the WAR cycle. Such parents can care and care very deeply for their children. It is the purpose of the kind of intervention being advocated here that they learn new ways to express that care.

4. The other children. Should the implementation of this program be affected by those children whose parents are not involved in their residential care? If we have learned anything from the child advocacy movement, it is that all children have rights. We have to be careful not to trample on the rights and feelings of any of our children. It doesn't seem, however, that a parent involvement program will violate the rights of children whose own parents are not involved. Our general goal is to provide them with a permanent place in the community; our efforts in that direction are not lessened by the presence of other parents. If their own parents cannot be a resource for them, it does not follow that we cannot provide every possible

opportunity for those children whose parents can be present.

As for their feelings, it is a fact that they live in a society in which they are reminded of the loss of their own family life. They know that that is why they are in residential care; they see other parents but not their own on visiting days; they see families in the community, on television, and so on. In this context, it doesn't seem that bringing other parents into the cottage will do any additional or unnecessary emotional damage. Indeed, there is evidence that it actually proves helpful. Child care workers have found that the feelings aroused in other children by this involvement have occasioned the constructive working through of loss and separation issues, helping the children to look to the future more realistically. Moreover, the parents' presence has served to remind the children of accepted community standards of behavior, when these parents have felt comfortable enough to disapprove of misbehavior.

In general, therefore, all seem to gain by children having parents present. Naturally, before the program begins, the group should be prepared for the arrival of the first parents. After that, it can become a matter of course. If a particular child finds the presence of another child's parents unbearable, special arrangements can be made.

There are probably specific problems unanswered by this discussion. These would need to be addressed in the context of the particular program. We advocate filling a gap that exists in the present provision of services for children in care. We do not propose that child care workers become "parent care workers" or that social workers abdicate their responsibilities. We look to the enhancement and enrichment of both disciplines with an eye toward hope and success for the children and their families. We seek to break the WAR cycle.

References (see pp. 172-177 for complete listings)

1. Ray E. Helfer, M.D., A Self-Instructional Program of Child Abuse and Neglect (East Lansing, Mich.: Michigan State University, 1974), Photocopy, 1-2. The various elements of the WAR cycle are also contained in different form in Ray E. Helfer and C. Henry Kempe, Child Abuse and Neglect: The Family and the Community.

2. Norman Polansky, "Prevalent Types of Neglectful Mothers," in Bernadette Ambrose, ed., Child Abuse and Neglect: Social Services Reader I (Albany, N.Y.: School of Social Welfare, State University of New York at Albany), pp. 74-77.

3. Albert Trieschman, "Understanding the Stages of a Typical Temper Tantrum," in Trieschman, James K. Whittaker, and Larry K. Brendtro, The Other 23 Hours (Chicago: Aldine, 1979), pp. 176-183.

4. John Bowlby, Attachment and Loss, Vol. I: Attachment, Vol. II: Separation (New York: Basic Books, 1969). See also "Loss, Separation and Placement," p. 107 of this curriculum; and Joseph Goldstein, Anna Freud, and Albert J. Solnit, Beyond the Best Interest of the Child (New York: Free Press, 1973). A movie that graphically depicts the traumatic effects of separation on a child in an actual case is John, 17 Months: Nine Days in a Residential Nursery, available through State University of New York at Albany Film Service, 1400 Washington Ave., Albany, N.Y. 12222.

5. David Fanshel, "Parental Visiting of Children in Foster Care: Key to Discharge?" Social Service Review 40, no. 4 (December 1975); and Fanshel, "Status Changes of Children in Foster Care: Final Results of the Columbia University Longitudinal Study," Child Welfare 55, no. 3 (March 1976).

6. Fanshel, Parental Visiting," p. 502.

7. Ibid.

8. For a study that found different correlates of high parental visiting, see John B. Mordock, Ego Impaired Children Grow Up: Twenty Year Follow-Up Study of the Astor Home for Children, (Rhinebeck, N.Y.: Astor Home for Children, 1978), pp. 191-197. However, as Mordock implies, the quality of visiting is important, since his "visited children" were not "beneficially involved with parents in other ways" (p. 196). All in all, we believe Mordock's findings support rather than weaken Fanshel's.

9. See "Child Care Practice, Section I: Goal Planning," p. 209 of this curriculum.

10. Uniform Case Recording Standards: Casework Manual, New York State Department of Social Services, January 1981, p. 44.

11. See the Annotated Bibliography of this module, p. 172.

SESSION OUTLINE: WORKING WITH FAMILIES

Time:	About 5½ hours
Space:	A large room; space for small group exercises
Equipment:	Overhead projector, screen Easel pad, stand, and markers

Materials: Handouts

- "Self-Assessment: The Child Care Worker and Families," p. 180
- "Ray Q - A Case Example," p. 10
- "Discussion Questions on 'Ray Q - A Case Example,'" p. 181
- "World of Abnormal Rearing (WAR) Cycle" (see transparencies), p. 198
- "Needs of Families at Risk: Child Care Role in Intervention," p. 182
- Four Role Plays, p. 183
- "The Place of Families in Residential Treatment," p.191
- "Some Readings on Families and Working with Families," p. 193
- "Brainstorming Exercise," p. 195

Transparencies on WAR cycle, pp. 198-205

Note: Since this session is longer than a half day, a convenient place to break for lunch is noted after #3. For a full-day's training, lengthen or add activities.

1. Introduction and Warm-up 25 minutes

a. The trainer distributes the handout "Self-Assessment: The Child Care Worker and Families" and asks participants to respond to the statements by filling in the "before training" boxes. The trainer explains the importance of participants' repeating their self-assessments at three months and six months after training. After the last assessment, they are to return the completed form with their comments to the trainer.

b. The trainer asks participants to pair up with someone with whom they are comfortable and then to describe to one another their emotional reactions to the families of the children with whom they work. Each member of the pair has five minutes.

c. The trainer lists on a flip chart the emotional reactions as they are volunteered by the participants. These are discussed by the group. The trainer must recognize and accept all feelings as real and important and natural. Since one of the purposes of this session is to help workers deal with their feelings, the trainer observes that awareness of the reactions is the first step. The other steps will be dealt with in other parts of the session by examining the role of the family and family dysfunction. There will also be a discussion and examination of the role of the child care worker with the family.

2. Small Group Exercise: Case History 45 minutes

a. The trainer divides the group into several smaller groups and distributes the "Ray Q - A Case Example" handout. Each group is to read the case history, respond to one of the questions at the end of the summary (group #1 takes question #1, etc.), and report to the large group its response to that question. The groups are given 20 minutes for this part.

b. Each small group reports its findings to the others. A good way to open this reporting session is to ask group members if they found the case similar to cases they have experienced, and what was the significance of the family for the child. Also, the trainer can relate the list of weaknesses of the family to the WAR cycle presentation; he or she can do so by interjecting some of the words from that theory as synonyms for weaknesses singled out by participants.

3. Lecture Presentation: The WAR Cycle 45 minutes

This is long for a training lecture. Still, the importance of the material and the details of the content seem to warrant it. The trainer can begin by giving everyone a five-minute stretch. He or she then can present the WAR cycle theory as discussed in the resource paper, using the overhead transparencies at the appropriate points and distributing them as handouts.

The lecture can be broken up a bit by asking participants to suggest examples of the various WAR cycle dynamics that they have experienced in children and parents and by encouraging questions. The trainer can also make clear correlations between the theory and appropriate child care worker interventions.

BREAK OR LUNCH

4. The Child Care Role with Parents: A Mini-Case 45 minutes

The purpose of this exercise is to begin narrowing in on the idea that child care workers have a proper and contributory role in working with the parents of the children in placement. But at this point the participants are only given the following instructions: Ray Q has been placed as a resident in your unit. You have been told that Rebecca Q., Ray's mother, will be visiting the unit for two hours per week during your shift. During those times there will be adequate coverage so you can devote your attention to Rebecca and Ray.

a. In small groups, the participants are to brainstorm, i.e., list as many as possible, responses to the following questions (for five minutes only):

Group 1: What are the benefits of this arrangement for Ray?
Group 2: What are the benefits of this arrangement for Rebecca?
Group 3: What are the problems and benefits for you, the child care worker?
Group 4: What are the problems and benefits for the other children?

b. Each small group then presents its list to the total group. The trainer should attempt to focus the discussion on the real issues: that there are significant benefits for Ray and Rebecca in such an arrangement, that there are benefits for child care workers and the other children, that there are problems that have to be faced, that the child care worker's feelings about this need to be validated and discussed. Ask them what they would do with Rebecca during the visits. At this point some discussion about setting up a visiting program will naturally arise. This issue can be acknowledged but is not the primary focus here. What is important is that the workers (1) see the benefits and (2) see themselves as having a significant contribution to make. This second point can be dealt with by simply reminding the participants of the WAR cycle and Q-family background, and asking them what they, as child care workers, could do for Rebecca during the visits. The feedback can be enhanced by distributing the handout "Needs of Families at Risk: Child Care Role in Intervention."

The discussion can be shortened, if necessary, by indicating that these issues will be faced in a different way by the next set of training activities.

5. Role Plays: Child Care Workers and Families — 2 hours, 15 minutes

The purpose of the four role plays is to explore in further detail the role of the child care worker with parents and families and to discuss further the problems and issues related to that role.

Special instructions for the trainer: Your role is to moderate and facilitate the activity, discussion, and learning. In role plays, you have to provide safety for the participants, so that they experience their role and do not feel threatened. It is important to give clear directions and provide boundaries for the discussion of the role plays. You need to help participants keep in mind that the roles are being explored and critiqued, not the individuals who are playing the roles. Through role playing, however, the participants are offered an opportunity to develop attitudes and to evaluate their own skill level, as well to experience the attitudes and feelings of others.

You may have to bring out any training points that the participants miss on the significance of families, dysfunctional family systems, and the child care worker's intervention methods with families.

You also need to provide support and positive reinforcement for the role players. You must highlight positive behavior that is portrayed, especially that of the child care worker, and any empathetic insights that occur during the role play. You may have to assist the persons who play the parents. In past use of these role plays, workers have ignored or forgotten that Rebecca is a WAR cycle parent whose actions and limitations are a function of those dynamics. You have to show how blaming, hostility, etc., are inappropriate for such interactions. The observation group, which has the job of identifying with Rebecca's feelings, can also be helpful.

These role plays are presented as samples. The first two explore the various attitudes and feelings of child care workers and families. The second two explore specific child care skills for working with parents. Variations can be used depending upon the experience of the participants and actual agency procedures. For workers already in contact with families, even in a limited capacity, role plays can be developed based on actual cases. These role plays can be used to explore feelings about working with the particular family or to identify skills that can be employed to meet the actual treatment needs of the child and his family.

a. The trainer explains the purpose of the role plays and divides the group into several smaller groups, depending on the number of participants and the amount of time available. Half of the groups will concentrate on role plays designed to explore attitudes and feelings; the other groups will look at development of skills. All groups can prepare their role plays simultaneously, perhaps in breakout rooms (15 minutes). Later when one group presents, the other participants will observe, using guidelines that the trainer gives them.

Each role player will receive a situation description and a specific role. The trainer should answer questions at this point. He or she may suggest that in playing their roles, the participants can utilize any insights or facts about the case, as well as their knowledge of the WAR cycle. They will also find useful their own experience with children, families, and other staff. They may need to improvise and elaborate on the given situations.

Each role play has assigned parts; additional parts can be improvised as needed, depending on group size. Suggestions are offered for extra parts. The role plays have been designed for five or six people. The trainer must make clear that each role play will be limited to a maximum of 10 minutes.

b. In starting each role play, the trainer will ask the players to briefly announce their roles and one person to set the scene. The trainer may have to interrupt the role plays when time is up or when the players need assistance. At the beginning of each role play, the trainer can assign the observation roles. Written observation sheets may be used. In processing the role play, the trainer has to ask the observers to address their questions to the role players, as the characters played rather than as individuals. This provides safety for the players.

c. After the role play, the trainer will ask each player to step out of his or her role. This is called debriefing and it is accomplished by calling the player by his real name and asking how how he felt about being the character in the role play. For example, "Fred, how did it feel to play John, the child care worker?" This helps them disassociate and not to personalize the role.

To keep the discussion focused, the trainer must be sure that the relevant issues are being addressed. He can do this by concentrating on the role players' feelings and the effect of their behaviors on one another. Discussion after each role play takes about 20 minutes. However, if the trainer feels that the discussion of one of them is fruitful, he can ask the participants (especially those who have prepared other role plays) whether they would be willing to omit one or more of them so that there is enough time to continue the discussion. There should be a fifteen minute break halfway through the role plays.

After the discussion of the final role play, the trainer distributes "The Place of Families in Residential Treatment" and "Some Readings on Families and Working with Families."

6. Bridging Exercise: Brainstorming 10-15 minutes

This exercise assists the worker in making on-the-job use of the knowledge or insight gained during the session. It is a bridge, linking training and practice. The handout "Brainstorming Exercise" is distributed. The exercise may be done by small groups or by individuals. The task (15 minutes), as described in the handout, is to give three examples of what they could do within the agency to have more effective contact with parents. Advanced workers who do work with families list three techniques they could or do employ with a particular case of their own. The small groups or individuals are asked to share their ideas with the whole group.

7. Final Activity 5 minutes

The trainer asks participants to write "I learned" statements about their experience in the session and about families, the WAR cycle, the child care role, etc. The participants can volunteer to share their statements, and the trainer then closes the session.

ANNOTATED BIBLIOGRAPHY

Adessa, Sylvester, and Laatsch, Audrey. "Therapeutic Use of Visiting in Residential Treatment." *Child Welfare* 44 (May 1965).

Although cautious, this article states some basic, worthwhile points. The authors believe that, through careful handling of visiting arrangement variables, the stress generated by visits has therapeutic potential. They offer guidelines for these variables based on their experiences at a children's center in Wisconsin. They also touch on intervention techniques helpful to the child care worker in working with families.

Alpert, Stewart W., and Starr, Philip. "A Family Centered Approach to the Treatment of Emotionally Disturbed Children in Placement." *The Forum for Residential Therapy* 2 (spring 1971).

The article outlines the agency's major tasks once a child is placed: (1) helping the family accept its child care responsibilities; (2) preventing the child from being alienated from his family and community; (3) establishing a permanent home for the child if return to his own home is impossible; and (4) minimizing the possibility of replacement.

It goes on to state that agencies have been unable to deal effectively with these tasks, for they see the child as the primary client as opposed to the total family. The authors suggest that the focus of therapy should be reestablishing the family as a unit or helping the child accept a life away from the family. Families must be involved in the decision-making process. An excellent article that provides the rationale for active family involvement in the residential treatment center.

Beker, Jerome. "Editorial: Professional Child Care - Maximizing the Impact." *Child Care Quarterly* 2 (fall 1973): 165-166.

Included here as a dateline reference. In 1973, family work was seen as a major part of the child care job of the future. To date, child care workers and agencies in New York State continue to focus primarily on children.

Bertcher, Harvey J. "The Child Care Worker as a Role Model." Child Care Quarterly 2 (fall 1973): 178-191.

Although this article is written about child care workers as role models for children, the principles can be applied to work with families. Unfortunately, the article implies that contact between natural families and child care workers is probably more trouble than it is worth. Bertcher, however, does seem interested in workers being looked upon in a more professional light, especially through involvement in decision making. Role modeling literature suggests that effective models are seen as having power and being respected. Thus, before child care workers can be successful in changing the behavior of children and parents, they and the administration must recognize child care as a full-fledged profession.

Child Welfare League of America. From Chaos to Disorder: A Collective View of the Residential Treatment of Children. New York: 1972.

In "The Family and the Treatment Center," a committee of nationally recognized professionals surveys the current beliefs and observations connected with family work. A list of questions are posed for future research on assumed and actual practice, on various models of treatment that include families, and on techniques of treatment as they relate to work with the family.

Children's Defense Fund. Children Without Homes: An Examination of Public Responsibility to Children in Out-of-Home Care. Washington, D.C.: 1978.

A study of the foster care system of seven states (New York is not included), documenting the problems and inequities inflicted on children and families by foster care systems. This work provides the worker with a national perspective and inspiration to continue advocacy for the child. Of special note here is the chapter, "Families Don't Count: Severing Family Ties," which describes policies and practice that result in the dissolution of family ties.

Fanshel, David. "Parental Visiting of Children in Foster Care: Key to Discharge?" Social Service Review 40 (December 1975).

The point is made that discharge rates are closely linked to the frequency of parent visitation, with high visiting leading to discharge. Fanshel recommends that agencies carefully monitor parental visits and be held accountable for efforts to involve parents in visiting. A thorough and professional job.

———. "Status Changes of Children in Foster Care: Final Results of the Columbia University Longitudinal Study." *Child Welfare* 55 (March 1976).

For those interested in a longitudinal study that analyzes the departure of children from foster care, the number of moves in care, and other status changes, including adoption and hospitalization. Factors significantly predictive of discharge include frequency of parental visits, investment of casework service, and casework assessment of overall parental performance of the mothers.

Finkelstein, Nadia E. "Family Participation in Residential Treatment." *Child Welfare* 53 (November 1974): 570-575.

Guidelines and options are given for a treatment approach that deals with the total family system. It calls for flexibility on the part of the agency to adapt rules and regulations to meet parental goals, and for professional disciplines to be used according to client treatment need, rather than traditionally defined professional role models. The role of the CCW with families is reviewed. Numerous services that a CCW can provide are listed, e.g., nurturing the parents, providing attitudinal models and teaching parenting skills both on agency grounds and on home visits. Emphasis is placed on the need for home visits as an important part of treatment if the child is to return home.

Foster, Genevieve, et al. *Child Care Work With Emotionally Disturbed Children*. Pittsburgh: University of Pittsburgh Press, 1972.

The section "Family Contact and Relationships" explores a worker's self-awareness when discussing and dealing with families. However, the authors present a conservative outlook that limits contacts between child care workers and family to brief encounters and directs workers to channel parents to other professionals to avoid confused communication.

Glickman, Ester. "The Planned Return of a Placed Child to Own Family." *American Journal of Orthopsychiatry* 23 (1953): pp. 834-847.

Glickman gives a detailed account of her work in reuniting Shirley, age five, with her mother after two years in placement. The case depicts the significance of the natural bond between mother and child and the diligent efforts of a worker who saw strengths in a multi-problem family. Glickman elaborates on how she supported the mother in planning the return of her young child and the work done simultaneously with Shirley to resolve her anger over being placed. The article underlines the importance of the family as a valuable resource.

Helfer, Ray, and Kempe, Henry C. Child Abuse and Neglect: The Family and the Community. Cambridge, Mass.: Ballinger Press, 1976.

The whole book is recommended for workers with a special interest in child abuse cases. Chapters 2, 11, and 12 are of particular help to residential child care workers. The first, "Parent-Infant Bonding," describes studies that validate specific periods of time that are crucial to the development of a parent-child bond. It offers recommendations for procedures that would intensify and insure this process. Stages of loss and separation are touched on, and how they affect the bonding is discussed. The other two chapters tell of concrete methods employed in rehabilitating abusive families. "Residential Therapy - A Place of Safety" is an exciting concept that recommends moving families into residential treatment centers, where a multidiscipline staff offers intensive therapy over a short period of time. "Practical Ways to Change Parent-Child Interaction in Families of Children at Risk" is a meaty how-to article that suggests employment of simple techniques for restructuring interaction between parents and children. Behavior modification as well as posted reminders of age-appropriate behaviors, posted cartoons of inappropriate responses, role modeling of positive attention, contracting, and stimulation programs are explored.

Keith-Lucas, Alan, and Sanford, Clifford W. Group Child Care as a Family Service. Chapel Hill: University of North Carolina Press, 1977.

An important book. So far as we know, it is the only child care book published to date that focuses on the need to work with the family as a whole. It has a well-written section on "The Development of the Children's Home," which observes that many children's homes today "still think of themselves as supplanting rather than supplementing family life." The description given of the family and child experiencing the children's home is sensitively written and emphasizes the need for good planning and extensive child-parent contact.

In "Part Two, Essays on Specific Topics," there are practical discussions of the various helping methods of children's homes, from planning to advocacy. Of special interest here is a panel discussion, "The Parent as a Member of the Decision-Making Team," in which a parent, a child care worker, and a social worker describe how they came to work together on the problem behavior of the child. Not only does the discussion reveal the feelings of all those involved, but it also demonstrates that parents can be an effective part of the team without an elaborate program.

For anyone who wishes to see a sensitively drawn picture of how a progressive agency can develop - from maintenance to administration - this book will answer the need.

Klein, Alan F. The Professional Child Care Worker: A Guide to Skills, Knowledge, Techniques, and Attitudes. New York: Association Press, 1975, chapter 15.

Klein's book is rich with examples of direct child care practice. In "The Place of Families in Treatment," he presents a child care worker's perspective on his role with actual families and a social worker's view of child care involvement with families. He also explores the team approach to family work and the tasks child care workers can perform in bridging the culture gaps between home and institution, developing a child's identity when his family is not a resource, utilizing the community, and termination from the agency when a child returns to family life.

Mandelbaum, Arthur. "Parent-Child Separation: Its Significance to Parents." Social Work 7 (October 1962): 26-35.

This article gives workers some understanding of the feelings of both parents and children on placement. This empathy can direct workers in their intervention techniques in helping families through this difficult time.

Minuchin, Salvatore, et al. "The Study and Treatment of Families That Produce Multiple Acting Out Boys." American Journal of Orthopsychiatry 34 (January 1964): 125-133.

This article gives insights into family dynamics of delinquent children. The areas of parental control, guidance and nurturance, as well as the sibling subsystem are explored.

New York State Department of Social Services. "Administration Letter 100." September 27, 1976.

This document contains New York State's regulations on case planning for children placed in foster care, including residential care, that have the overall purpose of preventing unnecessary prolonged separation of a child from the family. These regulations took effect January 1, 1979. Goals of short, intermediate, and long range are defined; several other important topics are addressed. Of relevance here is that family contact with the child is stressed and provided for.

New York State Department of Social Services. Uniform Case Recording Standards: Casework Manual. Albany, N.Y.: January 1981.

In 1979 the Child Welfare Reform Act made far-reaching changes in the foster care system in New York State. One such change was the creation of a Uniform Case Record (UCR) for recording case information, service plans, etc. The UCR Manual incorporates the ideas and principles contained in Administrative Letter 100. Where the two documents differ, the Manual supercedes the Letter. The UCR itself was put into use as of April 1, 1981, and as of that date became the most significant document in any child's case files, since it encompasses assessment information as well as the overall service plan.

Rhodes, Sonya L. "A Developmental Approach to the Life Cycle of the Family." Social Casework 58, no. 5 (May 1977): pp. 301-311.

An excellent presentation of the developmental crises facing any family, this article includes descriptions of both adequate and inadequate resolutions of such crises. Recommended.

Suchotliff, Leonard. "Crisis Induction and Parental Involvement: A Prerequisite of Successful Treatment in an Inpatient Setting." Adolescence 13 (winter 1978): 697-702.

This article explores involvement of parents in dealing with program "crises." This allows workers to see firsthand how the family interacts under conditions of stress and permits systematic interventions into this system. If the child is to return home, the parents and the child must be convinced that changes in behavior are a result of their methods of interacting with each other and not merely a result of "magic" or contact with new sympathetic adults outside the home. Good rationale for why we should bring families into our residential setting.

Webster, Christopher David, et al. "The Child Care Worker in the Family: Some Case Examples and Implications for the Design of Family Centered Programs." Child Care Quarterly 8, no. 1 (spring 1979).

The role of the child care worker as prime therapist in work with families is explored. Behavior modification procedures in the context of the child's natural social environment are utilized. Four cases are given primarily with autistic children. From each case the reader learns what techniques were used and some general points that are applicable to family-centered child care programs. This exciting article demonstrates that CCW skills are effective in treating the total family. A challenge to those who read it.

HANDOUTS

SELF-ASSESSMENT: THE CHILD CARE WORKER AND FAMILIES

By using this form you can determine how effective the training has been. Please be as honest with yourself as you can.

In the appropriate box below, respond to the following items. Answer "yes" or "no" to (a) and (b). Use the number on the scale that most closely represents your level of activity for (c), (d), and (e). Repeat this process at three and six months after training.

a. I know at least one theory of family dysfunction and how to use the dynamics mentioned in that theory to identify family dysfunction from a case record.

b. I know what child care worker role functions can be used in helping the parents of the children with whom I work.

c. I make it a point to understand the family dynamics of each child with whom I work and how the child's family is important to the child.

d. I make it a point to discuss each child's family situation with the social worker and other professionals.

e. I make it a point to utilize consciously and in positive ways the contacts I have with family members.

1	2	3	4	5	6	7	8	9	10
never		occasionally		sometimes			often		always

	a. Family theory	b. CCW role and family	c. Family dynamics	d. Discuss families	e. Utilize contacts
1. Before training					
2. Three months after training					
3. Six months after training					

Hopefully, training will help increase your activity and knowledge in each of these areas. If not, please try to determine why, and then share that information with your trainer.

DISCUSSION QUESTIONS ON "RAY Q - CASE EXAMPLE"

Read "Ray Q - A Case Example."

There are elements of the family history that have caused Ray's problems and are demonstrated through his behavior. Give specific examples of both family elements and Ray's behavior in regard to the particular questions assigned to your group.

Questions:

1. What are the strengths of the family and of Ray?

2. What are the liabilities of the family and of Ray?

3. What is your emotional reaction to the family and Ray?

4. Why is Ray's family significant to him?

NEEDS OF FAMILIES AT RISK:
CHILD CARE ROLE IN INTERVENTION

1. Ability to set appropriate limits

Objective: To develop parents' ability to set appropriate limits.

Example of intervention: Invite parents to observe the CCW at work. Afterward parents and CCW can discuss instances of limit setting that occurred in parents' presence.

2. Age-appropriate expectations

Objective: To help parents assume an appropriate parenting role.

Example of intervention: Accompany the child on a home visit to model proper parenting roles, e.g., sharing a picture book with child.

3. Good self-esteem

Objective: To enhance self-esteem.

Example of intervention: Give the parent a chance to assist in carrying out a cottage activity, thus giving him or her a feeling of confidence.

4. Connection with sources of emotional support

Objective: To increase parents' ability to recognize and use emotional support.

Example of intervention: Share with parents the child care team's sense of frustration over child's problem behaviors and team's use of support for those situations.

5. Capacity to trust

Objective: To develop trust on the part of the parent. This would have to involve providing the parents with positive experiences.

Example of intervention: Invite parents to come to the cottage on a regular basis to observe the cottage program. This will make the unknown known and demonstrate in action the agency's acceptance of the parents' role in the child's life.

ROLE PLAY #1

Situation: A unit meeting. Topic on the agenda: families visiting their children in the unit as a part of treatment. Purpose of the meeting is to discuss feelings. There is no need to reach resolution.

Roles:

Supervisor	You are Susan or Steven Jones. You have been supervisor in the unit for two years. Families up to this point have had set visiting days and times and they met their children in an assigned reception area. Administration has decided to implement a new practice designed to be of more benefit to the children and families. In certain cases, families would be expected to visit their children on a weekly basis and participate in the therapeutic milieu. The goals of these visits would vary from case to case and would be determined by the treatment team. Please explore with your staff how they feel about this and what advantages and disadvantages they see.
CCW	You are John or Jill Jay. You are an experienced worker and you feel very comfortable working with your agency. You have never done family work before, but you are willing to try. You see advantages for the children.
CCW	You are Terry Wade. You are an experienced worker. This idea sounds really good in general for the children and families involved, but what about the kids without families? Won't this upset them? They are apt to be disruptive and abusive to the family.
CCW	You are Joan or John Fish, a worker with six months' experience. You are skeptical about having families visit. What if they ask you to work with a child's family?
CCW	You are Bill or Billie Reed. You have one year's experience. You have developed a good relationship with the kids in the group. You don't think that their parents' coming in will be helpful, in fact you see it as a setback for the kids. They all have good reasons to be angry with their families considering their backgrounds.

Observation Roles:

Each observing group is assigned one or two players to watch. They are to look for feelings (expressed and unexpressed), communications missed or made, support given or withheld, body language, and other relevant factors. In the processing of the role plays, the observers may ask a player about his or her feelings and offer any comments they may have. (Be sure to know whether the questions are for the character or the role player.)

ROLE PLAY #2

Situation: It has been decided by the team to invite Mrs. Q, Ray's Mom, to spend some time in the cottage setting with the other children and a child care worker. She will be coming in on Wednesday nights between 4:00 and 7:30 p.m. Tonight is the first time Mrs. Q is coming in.

Roles:

Rebecca Q You are Rebecca Q, age 29, with five kids. Ray, your 12 year old, has been placed in a cottage of a residential treatment center for older adolescent boys. You have been asked by the caseworker to come to the cottage and be with Ray once a week for a few hours. You have met all of the child care workers before at various meetings. You are curious about what goes on in the cottage and what CCWs do with Ray, especially compared to what you do. You are nervous about visiting, since you are not sure what they expect from you or how you can help Ray. You have mixed feelings about finding out.

CCW You are John or Jill Jay, one of Ray's child care workers. You have been asked by your supervisor to work with Mrs. Q on your shift when she comes into the cottage once a week. You have one year of experience and feel comfortable with your group. You have never done family work per se, but you are willing to try. You see advantages for Ray in having his mother come in.

You want to establish rapport with Mrs. Q and present yourself as a helping person.

You want to introduce Mrs. Q to the other children and the cottage structure and routines.

(If there are times during the role play that you would like advice on how to deal with the situation, an observation group has been assigned the role of coaching. Please feel free to ask them for suggestions.)

Ray You are 12 years old and have recently been placed in a residential treatment center because of shoplifting and truancy. You aren't sure about this place and the workers. You also are skeptical about your mother visiting, especially in the group.

Additional Roles:	Various children in the unit: Jim, Bill, Mike, etc. You are adolescents who have been placed because of various social and family problems.
CCW	You are Joan Fish providing double coverage while Mrs. Q is visiting.

Observation Roles:

Group 1	Pay special attention to how the CCW addresses the needs of this WAR cycle mother, in particular her capacity to trust.
Group 2	In watching the role play, try to identify with Mrs. Q. How are you feeling? What are you experiencing as you visit the unit?
Group 3	You are a coaching group. As you observe the role play, pay special attention to the total dynamics and be ready to offer any suggestions or ideas to the CCW if he or she asks for help during the role play.
Additional Roles:	If the trainer has a larger group, he may assign other observation roles. Examples:
Group 4	If an additional CCW was used in the role play, comment on the workers' ability to work together as a team and support each other.
Group 5	While observing the role play, put yourself in Ray's shoes. How are you feeling? What do you think about your Mom visiting the unit?

ROLE PLAY #3

Situation:	Mrs. Q has been visiting in the unit for several weeks. She appears to feel more comfortable and has begun to relax with the workers and the children. The CCW has just begun to focus on treatment goals, and recently it has become evident that Mrs. Q really has difficulty in getting Ray to pay attention to her and follow through on her requests. The CCW has decided to help Rebecca make realistic requests of Ray and then to help her set some limits for Ray when he doesn't follow through.
Roles:	
Rebecca Q.	You are feeling safer in the unit and actually have begun to like the other children and to trust John (Jill) Jay, the CCW. You are glad he is there to take care of Ray, since Ray often doesn't respond to your requests. You wish Ray would listen to you; it embarrasses you that he doesn't.
Ray	You are glad your Mom is coming every week, but things haven't changed that much. She still complains about you; nothing you do satisfies her, so why bother?
John or Jill (CCW)	You realize that Rebecca and Ray care about each other, but old ways of dealing with each other get in the way of expressing this. Rebecca is too critical of Ray and thus Ray tunes out on most of the things she requests. Your goal is to help Rebecca have realistic expectations for Ray. You decide that if a situation arises in the unit involving Ray, you will have Rebecca take a more appropriate role in deciding the suitableness of his behavior, whether limits should be set, and what the limits should be. An observation group has been assigned the role of coaching you. If you desire their input, feel free to stop and ask them during the role play.
Additional Roles	You are adolescent boys. You are always looking for situations that will be to your advantage in the unit. You are active, impulsive, but do know the limits and expectations when John or Jill is on duty.
CCW	Joan Fish - worker with six months' experience.
CCW	Bill Reed - worker with one year's experience. You have a good relationship with Ray.

Observation Roles:

Group 1	You are to coach John (or Jill) Jay if he asks for advice on appropriate CCW techniques/methods to use with Rebecca, Ray, or children in the unit.
Group 2	Put yourself in Rebecca's shoes and identify how you feel about the requests John is making of you (keeping in mind your WAR cycle background).
Group 3	Identify with Ray. How do you feel about your Mom's ability or inability to deal with you? How do you feel about John Jay's (CCW's) role?
Additional observation roles:	Identify with the other children. How do you feel about the amount of attention you are receiving? About John Jay's role with Rebecca? With Ray?

ROLE PLAY #4

Situation:

Mrs. Q continues to visit in the cottage. She has been doing so for a few months. The child care worker has observed that Rebecca is acquiring some ability to deal with Ray. She has taken on more of the parenting role with Ray when she visits. On occasion, however, Rebecca gets discouraged by Ray's stubborn defiance and his acting-out behaviors and she begins to feel defeated and hopeless. She feels that she has failed as a mother and that she is a bad person.

Roles:

John or Jill Jay

You are John or Jill Jay. You have developed a good relationship after three months with Rebecca. She has picked up on the role modeling you and the other workers have been providing. At times you have seen her give up her attempts with Ray and become discouraged and angry. At these times, she says, "It is hopeless, Ray will never be able to live at home." You think she needs to know others have difficulties with Ray besides her, and you want to support her and build her self-esteem. An observation group has been assigned the role of coaching you; if you want assistance, ask them at any point during the role play.

Rebecca

You are happy about the little success you have experienced with Ray; but as soon as things are looking good, he begins to get nasty and abusive toward you. It appears things will never be good for you and your kids. When things aren't good from the beginning, they never get any better.

Ray

Your Mom has been really great about coming every week. She has even begun to praise some of your school work, especially your woodworking projects. You don't know why she makes you so angry at times though; or why it's so easy to get in trouble with the other guys when she isn't there. You feel bad after yelling at her, but you can't always stop.

Additional roles:

Other children and other workers in the unit.

Observation Roles:

Group 1	You are to coach the CCW if he or she asks for assistance during the role play. You should offer techniques/methods for accomplishing the goal of building Rebecca's self-esteem and giving her emotional support.
Group 2	Identify with Rebecca. How do you feel about John's or Jill's intervention? Is he or she offering support? How do you feel about yourself?
Group 3	Identify with Ray. How is John's or Jill's intervention making you feel? Are you feeling support or scapegoating? How do you feel about yourself? How about your Mom?
Additional Roles:	Other groups may identify with the participants who are playing children in the unit or other CCWs.

THE PLACE OF FAMILIES IN RESIDENTIAL TREATMENT*

Purposes of Involvement

1. Parent involvement in the cottage

   Purposes:
   a. to help parents get to know the agency and its staff better, and to help develop mutual trust;
   b. to model attitudes and management techniques to the parents;
   c. to provide support to the parents;
   d. to help restate to the parents that they are, and will continue to be, of primary importance to their child;
   e. to provide the parents with some positive nurturing;
   f. to demonstrate that adults and kids can, do, and should have fun together.

2. Child care involvement with child and family in their home

   Purposes:
   a. to structure a successful home visit for child and family;
   b. to gain a better understanding of the child's home and environment in order to plan a more effective cottage intervention plan;
   c. to model attitudes and management in the family;
   d. to involve family members who cannot be reached in any other way;
   e. to work toward visits without supervision;
   f. to involve family members of the extended family for those children who have no natural parents to return to but who do need the sense of belonging and identity that an aunt, grandparent, etc., can provide.

How do you go about accomplishing this? Key ingredients are:

a. an experienced child care worker is needed;
b. the unit social worker and assigned child care worker need to work out specific goals and methods to accomplish these goals under the supervision of the team coordinator;

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* Based on Chapter 15 of The Professional Child Care Worker, by Alan F. Klein (New York: Association Press, 1975), and on Parsons Child and Family Center's "Preliminary Proposal for Intensive Family Involvement in Residential Treatment." Used with permission.

c. social worker and child care worker must then meet with the family and child to define goals, roles, and methods to be used;
d. team coordinator should continue to help social worker and child care worker work comfortably with each other, to define roles, and to assess progress. It is essential to preplan goals for specific visits and then to assess whether these goals have or have not been met.

Some concerns about involvement in the child's home:

a. who is responsible for the child's management in the home?
b. which issues are to be dealt with by which discipline? For example, does the child care worker involve himself in a marital problem, or does he refer it to the social worker?
c. what is the potential and to what extent can we maximize preventive assistance for other children in the home?

Some general concerns about having families in the cottage:

a. the assigned child care worker and social worker need to develop a sense of mutual trust and see that each has a unique contribution to make to this joint endeavor;
b. the social worker needs to make himself available during some visits in case he is needed during the family visit;
c. both workers need to be aware about which issues could best be dealt with by whom. This concern might diminish as more experience is gained by both;
d. how might the parents react to other children's behaviors?
e. do the other children in the cottage have any say in the decision to involve families in their living space?

SOME READINGS ON FAMILIES AND WORKING WITH FAMILIES

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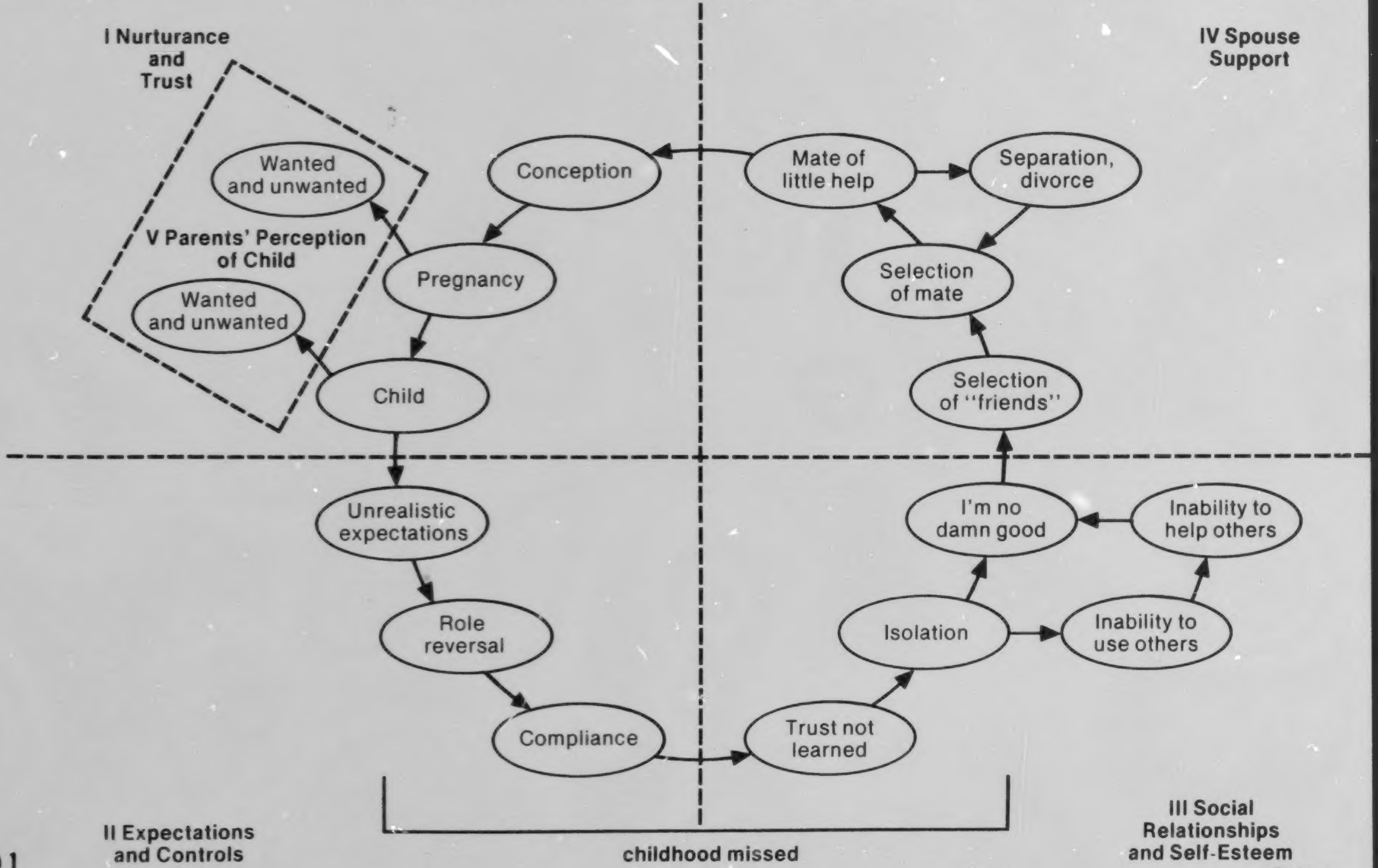
BRAINSTORMING EXERCISE

We have discussed our children's families in several ways throughout the session. The purpose of this exercise is to focus on actions of child care workers that can be helpful to parents within the present structure of your agency.

Task: Give three specific examples of things child care workers at your agency could do now to have more direct and effective contact with parents. (Don't focus on agency reorganization; focus on opportunities you may be overlooking at present.)

TRANSPARENCIES

WORLD OF ABNORMAL REARING (WAR) CYCLE



I Nurturance and Trust

V Parents' Perception of Child

Wanted and unwanted

Wanted and unwanted

Conception

Pregnancy

Child

IV Spouse Support

Mate of little help

Separation, divorce

Selection of mate

Selection of "friends"

II Expectations and Controls

Unrealistic expectations

Role reversal

Compliance

III Social Relationships and Self-Esteem

Trust not learned

Isolation

Inability to use others

Inability to help others

I'm no damn good

childhood missed

I. NURTURANCE AND TRUST

Total dependence of infant

Two dimensions in meeting basic needs:

Physical care
  consistency, predictability

Interpersonal relationships
  sense of being loved, valued

Concept of mothering imprint

WAR cycle

Needs not met

Lack of nurturing relationship

Effect on child

Does not develop basic trust

Responds with depression, anxiety, anger;
  or blocks painful feelings, goes numb

II. EXPECTATIONS AND CONTROLS

Normal parenting role - meeting needs of child:
(learned role)

- Routine tasks
- Emotional giving
- Standards, expectations
- Controls

WAR cycle

- Unrealistic expectations

    - child strives for compliance
    - roles are reversed

- Effect on child

    - pseudomaturity
    - missed childhood

- Inappropriate controls

    - rigid
    - absent
    - inconsistent or spotty

- Effect on child

    - abuse
    - deficiency in areas of controls

Controls - not inborn, but learned

1. Initially, come from outside (parents)
2. Control self to avoid punishment
3. Control self to keep love of parent
4. Control self to please self
5. Internalized, become a habit

To learn controls, child needs:

1. Love
2. Consistent limits

III. SOCIAL RELATIONSHIPS AND SELF-ESTEEM

Ability to turn to others = coping skill

WAR cycle

Isolated

- have to depend on self
- no lifelines, can't ask for or use help

Poor self-esteem

- can't help others
- missed feeling loved, valued
- missed feeling competent

Effect on child

- no "cushion" for periods of stress
- constant need for reassurance, approval
- vulnerable to criticism

IV. SPOUSE SUPPORT

Support in child rearing by spouse

- Emotional support
- Relief from actual tasks

WAR cycle

- Poor choice of mates
- Mates often unhelpful, unsupportive

Effect

- Dissatisfaction, conflict
- Abandonment of union
- Emotional divorce, unhappy clinging together
- No "escape hatch" for problems

V. PERCEPTION OF CHILD

WAR cycle

Baby seen as solving parents' problems
Conception becomes a major goal

Wanted conception/wanted child

Pregnancy might become unwanted
Child might become unwanted

Distorted perception of child

Child as different from expectation
Twisted belief about how child views parent
Child perceived as like somebody
Image of child fused with own image

WAR cycle begins anew

SUMMARY: CHILDHOOD MISSED

Significant gap in developmental processes of WAR cycle children

Miss out on large segments of childhood:

- Being treated as a child
- Developing trusting relationships
- Learning many of the social skills
- Feeling good about themselves

As adults

- Conflict between unmet dependency needs and lack of trust
- Poor self-esteem, isolation, lack of social skills
- Lack of joy
- Inability to cope with stress

Turn to their children and cycle continues

Child Care Practice

by Patricia O'Donnell,
Wayne Ouderkirk, and Anne Stea

INTRODUCTION

Several things need to be said about this section. First, the title. There does not seem to be an agreed upon term that encapsulates what child care workers do. Instead, various terms like "treatment," "child care work," "child caring," "milieu therapy," and "child care intervention" are used; but it seems that no one of them says it all. We have chosen to use the phrase "child care practice" because it seems more neutral in relation to the other disciplines included in residential care. By the phrase we refer to the set of professional activities that constitute the child care worker's job.

Second, we do not claim to be able to include here everything that child care workers do. That would not only be impossible but also undesirable. We want to deal with some of the more salient features. Other features form the topics of other modules, e.g., programming, understanding families, crisis intervention, etc.

That brings us to the third point about this module: it has three separate parts. In the first part, we deal with goal planning. This is a crucial part of child care practice. Without conscious, deliberate planning, child care practice is reduced to child care reaction; and the role of workers is thereby reduced in significance.

However, as specific as goals must be to be useful, the ability to write them does not imply the ability to implement them. Hence, in the second and third parts of the module, attention is given to specific techniques that child care workers can and do use in implementing goals. In daily practice, there is a constant interplay between goals and techniques. The goals influence the way in which the techniques are used; the use of techniques -- their results -- in turn modify the goals. It is only for training purposes that the two are separable.

Since there are three separate sessions described herein, the contents relevant to each are given in their respective contexts.

SECTION I: GOAL PLANNING

BEHAVIORAL OBJECTIVES

After participating in this session, participants will be able to

1. Identify and explain the five steps of goal planning
2. Identify and explain the categories for describing problem behaviors
3. Use the categories to describe a problem behavior of a child in their care

4. Identify an appropriate short-range goal for one child in their care and a child care technique that will aid the child to accomplish the goal

5. Identify an appropriate medium-range and long-range goal for a child in their care

BEHAVIORAL CHANGES

1. The worker will be more likely to attempt to describe negative behaviors by means of the categories treated in this session.

2. He/she will be more likely to consult with children's psychotherapists regarding relevant clinical issues.

3. In verbal and written communication the worker will be more likely to refer his or her reports to specific short-range, medium-range, and long-range goals.

4. In working directly with a child, the worker will attempt to accomplish the child care tasks that will assist that child in accomplishing short-range goals.

RESOURCE PAPER: CHILD CARE GOAL PLANNING

Children come to residential caring agencies because they have problems that cannot be dealt with in the home or another setting. Inevitably, they are referred to us not because of what they think or what they feel, but because of behaviors that are unacceptable to society. Our purpose is to help them develop patterns of behavior that are within the norms for their community or family group. To attain this main goal we formulate a treatment or service plan.

In agencies that have accepted the concept of the professional child care worker, the worker has become intimately involved with the formulation of the service plan. An experienced child care worker possesses special skills and abilities that develop out of the special requirements of the job. He or she develops a "feel" for the particular group or child that may not be possessed by practitioners of other disciplines who deal with children. Child care is a practical art: what will or will not work takes precedence over what should or should not work. Because the child care worker possesses a sense of practicality and propriety, he or she can be the most effective person to formulate the plan that he or she will carry out.

This is not to say, however, that the child care worker can work in a vacuum. He or she depends upon the knowledge, recommendations, and observations of the family, child, and such staff members as the psychiatrist and social worker to provide information about the child's history, the causes of inappropriate behaviors, motivational factors, and suggestions for treatment techniques. The combination of the input from other professionals with that of the child care worker is used in formulating the goals that the treatment team will work on with the child in each professional's specific way.

Even where the child care worker is not intimately involved with the formulation of the treatment plan, that worker is nevertheless involved, perhaps more intimately than any other professional, in the carrying out of that plan. The achievement of life skills and the learning and use of appropriate behaviors by a child are carried out in the context of the child's everyday life. And it is there that we find the child care worker. Thus, the worker could be given a part of the job of accomplishing a general treatment goal. To that end, the worker must be able to formulate specific goals that can lead to the accomplishment of a general goal.

Goals can take many different forms. But often goals are too general. There are numerous examples of general goals: increased self-worth, increased ability to handle stress, increased ability to handle responsibility, increased ability to form relationships. To be helpful to anyone, we must make them more specific.

An example of a specific goal leading to increased self-worth could be: the child will improve his physical appearance and will verbalize positive feelings about himself; more specifically, he will wear appropriate (clean, matching, mended) clothes to school 50 percent of the school week and will call worker's attention to the clothing.

An example of a specific goal leading to increased ability to handle stress and anxiety might be: the child will no longer fight when angry; the child will tell the worker at least once a day that he is very angry, instead of striking out physically or verbally.

The specific goals are obviously much more useful and measurable for child care workers--or anyone else working with a child.

What is still missing from the specific goals given above is a time frame; and the time frame determines whether the goal is short, intermediate, or long in range. Fixing a deadline for accomplishing a given goal is helpful for several reasons.

First, it provides us with a defined situation, rather than an open-ended one. This is especially crucial in child care in New York State, which is attempting to limit the length of time children remain in placement in an effort to eliminate "foster care drift."[1] In its Administrative Letter 100, the New York State Department of Social Services has issued guidelines for county and agency caseworkers that apply to children placed in residential care.[2] Also, as mandated by the New York State Child Welfare Reform Act of 1979, the state's Department of Social Services has instituted the use of a Uniform Case Record (UCR) in all foster care cases. In the manual giving directions and standards for the use of the UCR,[3] there are some structural and terminological changes made from those contained in Administrative Letter 100. However, the basic principles of case planning are shared by the two documents. We have chosen to retain the terminology of Administrative Letter 100 for several reasons. First, the actual use of the UCR in any foster care placement will fall to the county or agency caseworker, not to the child care worker. So more often than not, the child care worker will be designing child care goals based on the UCR case plans. In doing so, he or she need not rely on UCR terminology. Child care workers who do participate in the formulation of UCR case plans will be working closely with the caseworker, who will be familiar with UCR terminology and who can provide the necessary technical assistance.

Second, given the increasingly limited time-span for residential placements, we feel that the temporally fixed goal definitions of Administrative Letter 100 provide a highly useful set of reference points for child care work. It seems to us, using UCR terminology, that many of the child care worker's goals will fall under the "Client Objective/Task" and "Method/Service Task" portions of the plan.[4] These portions of the UCR Comprehensive Service Plan do not themselves require time frames (though they fall under goals which do require time frames). Thus, for child care work, we feel that using the definitions given here will provide added structure which will benefit the child, the family, and the worker.

Next, the UCR manual says that a client goal "is a statement that describes one desired outcome that the client will achieve or will occur as a result of providing services...." The client goal is to be written in terms of observable behavior; is to be desirable, realistic, and achievable; is to be clearly stated so as to promote understanding of what is expected; and is to be measurable (when appropriate) and time limited.[5] The discussion of goals presented here includes all of these characteristics. Thus, it conforms to present standards.

Finally, because it is possible that a child could be placed in residential care before the point at which the UCR requires a Comprehensive Service Plan (ninety days after application for services),[6] it would be advisable for the child care workers dealing with the child to formulate at least some short range goals on which the child and team may begin working. For example, some aspects of adjusting to loss and separation could be included here, as could obvious school and behavioral problems as well as efforts to integrate the child into the unit and agency. For these purposes the terminology of Administrative Letter 100 is quite useful. (It should be stressed that, where these two state documents happen to conflict regarding specific practices, the UCR standards take precedence.)

In the guidelines given by Administrative Letter 100, short-term goals are defined as goals that can be achieved in three months; intermediate goals are those that can be achieved within six months. Long-range goals are not actually defined by a time frame in the guidelines, except that they must be formulated, based on the realities of the case, by the end of the first year of the child's placement. An obvious time span for long-range goals in child care would be the length of the child's stay in residential care, since such placements are increasingly time-limited. (Examples of the three types of goals are given below.)

Fixing a deadline for accomplishing a goal not only provides a defined situation, as already discussed, but also offers a measure of success or failure. If the goal has not been accomplished by the deadline, perhaps it was too difficult or our sights were too high, or if accomplished quickly, perhaps our sights were too low. Thus, time frames provide us with a handy gauge by which we can test our efforts.

And finally, time frames can help us to reduce uncertainty in our work and in the children's lives. Part of our function as child care workers is to eliminate such uncertainty.

Writing goals or objectives for children in care can be viewed as a five-step process.

Step One: Defining the Behavior to be Changed.

The negative behavior to be changed* should be one that the child uses consistently. There could be many such behaviors exhibited by any given child. In addition to such consistent behaviors there are "tied to the moment" negative behaviors that a worker is legitimately concerned with controlling. How can we select one out of many things with which a child needs help?

There are several factors to take into consideration. One is that we are interested in developing the children's skills and behaviors that will be useful for them in the long run. So if a specific problem arises with a child in a specific situation, an effort must be made to determine whether it is related to any consistent pattern. Such patterns are the proper field of application for child care workers' efforts; reactions that are truly "tied to the moment" must be dealt with but do not call for extensive intervention.

But how can we determine whether a given reaction is part of a consistent pattern or not? In one sense, this is a silly question to ask child care workers. They know whether Johnny always does it or not. Still, there must be some work done in terms of identifying and describing a behavior we want to change. It is this process of identification that can help us distinguish patterns that need to be dealt with. Saying we want to change negative to positive behavior is too vague. As part of a child care plan we have to define the behavior we want changed.

We can specify that behavior and its alternative if we describe it by means of the following categories.[7] (Note that the use of these categories involves a high degree of staff communication, which enhances cooperation, which, in turn, enhances care of children.)

1. When the behavior typically occurs. This is obvious and thus easily overlooked. The behavior may occur only at bedtime. Even then, it may be possible to specify further, e.g., is it before or after lights out? When we are concerned about a behavior of a child, we tend to describe it as continual or constant. But when we step back from the situation, we often find a pattern connected with time. The pattern may even be related to staff scheduling. A time pattern reveals part of the behav-

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* Workers are also interested in developing positive behaviors in a child. The present discussion is phrased in terms of negative behaviors because the absence of a specific skill is usually manifested in some inappropriate--negative--behavior.

ior's meaning. A bedtime problem may relate to fears of being alone or abandoned, for example.

2. Frequency and location. Obviously these are related to when the behavior occurs. Here the questions are "How often?" and "Where?" Knowing the frequency of a behavior helps us define the patterns we are dealing with, as does knowing whether it is limited to a particular place or to several places or to none.

3. The people involved. This relates to both children and staff. Is it something the child does alone or with others? With the same others? Does it occur with one particular staff member only or with all? Knowing who is usually involved may give us an indication of why the behavior occurs. For example, could it be a problem a given child has in relating to females? Or to males? Or in resisting peer pressure? Again, we are seeking a pattern.

4. The pace and manner (or mode) of behavior. Pace simply refers to the intensity of the activity: could it be described as slow or vigorous, aimless or directed, etc.? The manner or mode specifies whether the behavior is physical or verbal, active or passive, and to what degree. For example, there is a difference between two children's bedtime behavior when one talks constantly to his roommate after lights out - a calm but intense pace, verbally expressed - and the other runs from room to room disturbing or attacking other children - a vigorous intense pace, physically expressed.

As Trieschman points out, with a new child or with a new worker, these four categories may be the only useful ones. As such, they constitute an important starting point for additional learning. However, over a period of time it is possible to use two further descriptive categories.

5. Developmental level. Can we determine a particular developmental task the child is working on with the behavior? For example, is a teenage boy's frequent fighting related to his attempts to find his male identity? The determination of such psychological factors is no simple matter, but it is nonetheless important for child care work. Here a knowledge of human development is crucial. Even if there is no developmental task that a child is working on through negative behaviors, the behavior pattern may indicate that the child has still not resolved a developmental issue that must be settled before age-appropriate behaviors can be expected.

6. Coping mechanisms. In psychological terms, these refer to defense mechanisms. Is the teenager mentioned above denying the gentler feelings he might have because he feels they are too feminine? Defense mechanisms are in no way abnormal; they cope with problems. This is perhaps the most difficult of the

categories to use. The use of this and the developmental level category may at times require the assistance of a psychologist or other clinician--not because child care workers are unable to deal with so-called clinical issues, but because these categories are two of the special areas of expertise of clinicians on the treatment team.

One other issue that must be dealt with when discussing the formulation of a plan to change specific behavior is the question of priorities. As mentioned above, any child could need to develop many new patterns of action. Which one(s) should we single out first? Many experienced child care workers prefer to deal first with behaviors they are sure the child can overcome; more problematic issues are faced later, after the child has had a taste of success. Others feel that the most socially unacceptable behaviors must be altered first. Apparently, there is no formula for deciding this question. The whole team - including, when possible, the child - must make the choice, based on a thorough knowledge of the child, the family, and the strengths and weaknesses of both.

Step Two: Translating the Problem Behavior into a Specific Goal.

We have already discussed the difference between general and specific goals and the time limits that help to specify them. Once a particular problem behavior is selected and thoroughly defined through step one, it can be used in the formulation of a goal to be worked on. An example will illustrate this:

> Craig, 14, is easily angered and expresses his anger physically and aggressively. He has at least one fight a day, especially when he is in an all-male peer-group situation. The staff has decided to attempt to get Craig to express his anger more appropriately, since he needs to function better in all group situations. He seems to be attempting to define himself, to find an identity, but he has adopted no appropriate role model. The staff feels that he is imitating the aggressive, violent models he has had and is displacing his anger toward them onto his male peers.

For Craig, a short-range goal tied to the problem of physical aggression might be:

> Craig will be able, within three months, to talk about any fights he gets into and will be able to accept the CCW's (or other adult's) intervention (e.g., stopping the fight).

In the intermediate range, a goal might be:

> Within six months, Craig will be able to leave the scene of a problem or difficulty rather than fighting unnecessarily.

While the most important long-range goal for Craig or any child concerns where he is going upon discharge from residential placement (the child's permanency goal), there are other long-term goals which are useful for all concerned. For example, our long-range goal for Craig might be:

> By the end of his placement in residential care (eighteen months), Craig will express anger more appropriately (e.g., verbally rather than physically).

Step Three: Determining the Cause* of the Behavior.

As mentioned in step one, developmental level and coping mechanisms, while descriptive of a behavior, can also be viewed as part of the cause. There are other such factors that must now be taken into consideration.

One issue involves the child's reaction to placement. Being sent to live in an institution or any place that is not home is a loss for a child; the child will react in a natural way that is called the grieving process (see "Loss, Separation, and Placement," pp. 111 ff). Here we wish to know: At what point in the grieving process is the child? At first glance, this may seem irrelevant to setting goals, since a child is usually placed for the purpose of correcting problem behaviors, and those behaviors are the ones with which we must deal. But additional problems can arise as a reaction to placement, and child care workers sometimes must deal with them first. To take a simple example, it is difficult to work on problem behaviors when the child is constantly running away as a reaction to being placed. Also, many of the children in residential care have experienced losses throughout their lives. In such cases it is crucial to determine how the child's present behavior relates to such losses.

Another important dynamic to be examined in this step is the family system of which the child is a part (see Children, Families, and Child Care Workers," pp. 149 ff.). Having a clear idea of the dynamics causing the behavior - developmental level, defense mechanism, stage of grieving process, family system - goes a long way toward determining how we will attempt to help a child change. And that brings us to the next step in goal planning.

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* Obviously, "cause" is being used in a very broad sense here. It is an extremely controversial issue in the philosophy of psychology whether human actions can be said to be caused in the strict sense of that term. But that is an issue that need not detain us here.

Step Four: Decide on the Appropriate Method to Achieve the Goal.

As child care workers, we have to use every possible method to help a child grow. Nevertheless, there are distinct methods on which we can concentrate for various purposes and for various children. This step does not require us to isolate critically one particular technique. Rather, the question is, which technique can we concentrate on and how do we want to use it?

The other parts of this module present two child care techniques and other modules present additional ones (see "Activity Programming," "Building Therapeutic Groups"). Among various methods not specifically discussed in the curriculum are group processes, community resources, behavior modification, and volunteers. As with any goal-oriented activity, in selecting a technique for achieving a specific goal, our primary consideration must be appropriateness. Is this particular technique suitable for attaining this specific goal? No matter what method we single out, one question must always stand out in our minds: Will it work? That is the point of the next step of goal planning.

Step Five: Determine How to Evaluate the Change in Behavior.

It is crucial for us to know whether or not what we are doing is working. Although it is not always simple or easy to determine the long-range effects of our efforts, we still must try to find ways to gauge our effectiveness. This is especially true given the time and money constraints on residential placements. We should make every effort to be as effective as possible in achieving goals.

One way to measure effectiveness has already been discussed: making our goal time-limited. At the end of the specified time we will know whether we have accomplished what we set out to do. Another factor in evaluation is to make goals as observable as possible. "Improved self-esteem" is somewhat intangible, but consistently dressing neatly is not. Being able to see progress of this kind is not only helpful to workers, but is also a concrete measurement for the child and family.

The evaluation process should be systematized as much as possible. Frequent, regular meetings of child care staff can be used for constructive review and reevaluation of the written goals. If goals are not being met, it is necessary to revamp or eliminate them.

Conclusion

Ideally, goal setting is a contractual situation between the staff, the child, and the child's family. Here we have only discussed the process from the child care worker's standpoint. Goals should be set as soon as possible, and refined as needed. Of course, it is important not to overload the child and family with too many tasks or too difficult tasks, as that only leads to frustration, anger, or apathy on the part of the child and the staff. It is better to concentrate on a few goals at a time. For everyone concerned, the plan has to be realistic, only attempting what can actually be accomplished. When describing problematic behaviors or the method to be used to treat them, the goal is to be very specific to ensure consistency among staff.

The emphasis in child care treatment plans is on the child's behavioral manifestations in the areas needing change. To deal with a child only on the level of feelings or thoughts does him a disservice. We can see exactly what a child does, but at best we can only guess at his thoughts or feelings. Therefore, it is safest to depend on the child's behavior to choose the areas we are going to treat. Helping a child express his thoughts and feelings as a treatment goal may make it less necessary for the child to act them out behaviorally.

Finally, if the child is not succeeding at the goal, it is necessary to reevaluate the plan and see whether all parties are committed to, and able to, change the problem behavior.

References (see pp. 241-44 for full listings)

1. David Fanshel, "Status Changes of Children in Foster Care."
2. Administrative Letter 100, New York State Department of Social Services, September 27, 1976.
3. Uniform Case Recording Standards: Casework Manual, New York State Department of Social Services, January 1981.
4. UCR Manual, pp. 57-61.
5. Ibid., pp. 40-41.
6. Ibid., p. 3, and pp. 57-61.
7. These categories are, for the most part, taken from Albert E. Trieschman, "Understanding the Nature of a Therapeutic Milieu," in Trieschman, James K. Whittaker, and Larry K. Brentro, The Other 23 Hours, pp. 5-17.

SESSION OUTLINE: GOAL PLANNING

Time: 2 hours, 40 minutes

Space: A large room; work space for small groups

Equipment: Easel pad and stand; markers

Handouts: "Self-Assessment: Child Care Practice," p. 246
"Five Steps of Goal Planning," p. 247
"Johnny Jones," p. 248

1. Warm-Up 5 minutes

2. Introduction 5 minutes

The trainer distributes the "Self-Assessment: Child Care Practice" handout and asks participants to respond to the statements by filling in the "before training" boxes. The trainer explains the importance of participants' repeating their self-assessments at three months and six months after training. After the final assessment, the participants are to return the form with their comments to the trainer.

The trainer introduces the topic of goal planning, explaining the importance and utility for child care practice of writing goals for the children in placement.

3. Steps for Writing Goals

a. Small Groups 10 minutes

The trainer divides the participants into small groups to list at least three steps that need to be accomplished to attain a goal of any kind. Each group will report its list after five minutes. Most, if not all, of the five steps of goal planning can be found on lists generated in this way.

b. Presentation 25 minutes

The trainer can then use the groups' lists to present and explain the five steps as described in the resource paper. The "Five Steps of Goal Planning" handout is also useful. Special care has to be given to the categories for describing behaviors, pp. 214-16. The presentation should also include an explanation of short-, medium-, and long-range goals.

4. Practice Writing Goals

a. Small Group Task 30 minutes

The trainer divides the group into small units (four or five people), distributes the handout "Johnny Jones," and asks the groups to read it. The task is to identify one problem behavior, one short-range goal, and one child care technique to aid the child in accomplishing the short-range goal. The group should choose a reporter who will present the goals to the whole group.

b. Processing 30-40 minutes

The trainer asks each group reporter to give the problem behavior, the short-range goal, and the child care method. He or she then leads a discussion of the group's plan by helping participants focus on the isolation of a problem behavior, translating the behavior into a specific goal, and utilizing an appropriate child care technique. Other groups are then asked to report their plans and share their data.

BREAK 15 minutes

5. Individual Exercise 20 minutes

a. Task

Each participant is to think of a child with whom he/she works who is relatively newly placed. The task is to use all five steps of the goal-determining process to write one short-range, one medium-range, and one long-range goal. In describing the behavior and the dynamics behind it, the participants should use as many of the categories as they are able, and then go on with the exercise.

b. Processing

Participants are then asked to form pairs, preferably with someone from their own unit, to review each other's treatment plans, focusing on specificity of the goals and feasibility of the child care plan and evaluation tool.

6. Final Discussion 10 minutes

The trainer can lead a discussion of problems that workers encountered in writing the goals in the two previous activities. The trainer's role here is to help the workers to find out how to overcome these problems in future attempts at goal writing. Resources at their own agencies are the most useful ones--experienced workers, supervisors, clinicians, etc. Participants can write "I learned" statements; volunteers can share theirs, and the session ends.

223

SECTION II: TEACHING ALTERNATIVE BEHAVIORS

BEHAVIORAL OBJECTIVES

After participating in this session, participants will be able to

1. Identify and explain the three steps of teaching alternative behaviors.
2. Demonstrate the appropriate teaching of alternative behaviors by role playing, given a specific case example.

BEHAVIORAL CHANGES

1. The worker will be more systematic and deliberate in dealing with children's negative behavior.
2. He or she will be more likely to select appropriate substitute behaviors for the child's use.
3. The worker will consciously use the technique of teaching alternative behaviors.

RESOURCE PAPER: TEACHING ALTERNATIVE BEHAVIORS

One of the many things child care workers do is to provide children with the opportunity to develop new ways of acting in different situations. The following description of this technique of "teaching alternative behaviors" is an outline of Trieschman's fine account.[1] The technique is based, of course, on the assumption that behavior, including negative behavior, has meaning. The goal of employing the technique is to help the child communicate that meaning in a positive, acceptable, or non-self-defeating way.

Before attempting to teach a new behavior, one must obviously select a behavior to be changed. The issues involved in that selection and the categories for describing the behavior are discussed in the resource paper on "Goal Planning." After identifying the behavior to be changed, teaching alternatives consists of three separate steps.[2]

First and most obvious, the child care worker must interrupt the negative behavior at an appropriate point. (Not all behaviors can be interrupted at just any point in their duration, e.g., a temper tantrum.) There are as many ways to interrupt behaviors as there are behaviors. Here the worker's style enters. Personal styles vary, but the interruption must be suitable to teaching the child something new.

If we only interrupted negative behaviors, child care would not be a professional activity. One therapeutic dimension of child care work enters in the second step of teaching alternative behaviors: the substitution of behavior. In this step the worker substitutes for the negative behavior an action the child already knows but is not using in the situation. There are several criteria for choosing the substitute behavior:

1. The child's intention: What need or meaning does the negative behavior express? The substituted behavior must fill this function. (See the discussion on dynamics behind behavior in the resource paper, pp. 214-17.)
2. Social acceptability: The substituted behavior must be one which is more acceptable to both the community at large and to the child's own society, i.e., his peers.
3. Age appropriateness: This is related to social acceptability. Some behaviors are appropriate for an eight year old, but not for a fourteen year old.
4. Capacity to diminish: The substitute behavior must be able to ease the self-defeat of the original behavior.[3]

There is a third step of teaching alternative behavior that is possible in some cases. This Trieschman calls invention of behavior. This activity involves teaching the child, or the child and worker teaching one another, new behaviors that were not a part of the child's range of possible actions. Learning new behaviors can open up new avenues for the child--self confidence, mastery, self-acceptance, awareness of possibilities, hope--which he needs in order to grow away from us.

An example: David, age ten, disliked one of the group's favorite breakfast cereals. The other boys teased him, calling him by the cereal's name. David, unable to tolerate teasing, responded by attacking his tormentors physically. After staff discovered the cause of his increased aggression, David was prevented from so responding (interruptions) and on each occasion was told to respond verbally - "telling off" the other boy in question. After continued pressure, he was able to do so (substitution). Still later, having mastered his impulse to strike out, David and the CCW evolved a little game. Whenever someone would attempt to goad him into a fight by name calling or by other forms of teasing, he and the worker would exchange knowing smiles or whisper a cereal name to each other and laugh (invention). Thus, he began to learn to ignore teasing and unnecessary comments from others.

Any experienced worker can tell us that it wasn't as easy as the example may sound. The teaching occurs over a long period of time, in the midst of attempting parallel interventions with other children, and in conjunction with other techniques and the work and assistance of professionals from other fields (teachers, psychologists, social workers). The focus was on one behavior; there may be many more that a child needs to work on with our help. But if it is used well and deliberately and consistently (i.e., by all the child care workers in relation to the same behavior), teaching alternative behaviors can be a powerful child care technique.

References (see p. 244 for full listing)

1. Albert E. Trieschman, "Understanding the Nature of a Therapeutic Milieu," in Trieschman, James K. Whittaker, and Larry K. Brentro, The Other 23 Hours, pp. 5-17.

2. Ibid., pp. 5-9.

3. Ibid., p. 7.

SESSION OUTLINE: TEACHING ALTERNATIVE BEHAVIORS

Time:	2 hours, 15 minutes
Space:	A large room, plus space enough for the worker to practice the technique
Equipment:	Easel pad, stand, and markers; videotape equipment optional
Materials:	"Role Play Illustrations," p.227

1. Introduction — 5 minutes

The trainer introduces the topic by defining the phrase "teaching alternative behaviors" and explaining its place in child care practice.

2. Role Play Illustrations, Discussion — 30-40 minutes

a. The trainer presents, either on videotape or with the help of volunteers, a missed opportunity for teaching alternative behaviors, such as the first one in "Role Play Illustrations." (If two participants volunteer to role play the situation, they must be either prepared in advance or allowed time to prepare.) After the illustration, the group is invited to comment on what went wrong with the encounter between worker and child. This discussion is a good lead-in to the next, more positive illustration.

b. The second illustration, demonstrating a positive instance of teaching alternative behaviors, is presented. Then the group picks out what the worker did that was positive. The trainer leads the discussion toward the listing by participants of at least the first two steps of teaching alternative behaviors, interrupting and substituting, and identifies them as such. The trainer can also explain the third component, invention, after the other two are discussed and explained, since the illustration does not contain this step.

BREAK — 10 minutes

3. Practicing the Teaching of Alternative Behaviors — 60 minutes

The crucial test for a worker's understanding this technique is whether that worker can actually do it. An important step toward attempting it with children is to practice it in role play situations. The trainer can form the participants into groups of three. Each member of each trio is then given an opportunity to practice the skill in an appropriate situation. The behavior may be one that the participant has experienced or the one described in the role play illustrations. One of the other members of the trio takes the role of the child in the situation. (This person may need to be briefed regarding the child.) The third person observes and then offers feedback to the worker practicing the skill. The roles are rotated within each trio so all three members have an opportunity to practice and to be offered constructive comments.

4. Summary 15 minutes

The trainer reconvenes the whole group and elicits any remaining questions. Then there is time given for participants to reflect on their learning, e.g., by writing "I learned" statements; volunteers could share their statements.

ROLE PLAY ILLUSTRATIONS

1. A missed opportunity for teaching alternative behaviors (5 minutes):

   Willie, 15

   You are returning from school, where you have skipped gym class for the third time this week because you feel the teacher dislikes you and treats you unfairly. You know you'll be in trouble but you just can't face that gym class any more. You accept your punishment but fail in your brief attempt to get the CCW to hear your problem.

   Al or Ann, CCW

   You have just had a call from the school principal, informing you of Willie's class cutting and threatening suspension. You greet Willie angrily, cut off his explanation, and give him an appropriate punishment and stern warning.

2. A positive attempt at teaching alternative behaviors (5 minutes):

   Willie, 15

   Same situation as before, except the CCW responds differently and you come to a mutually acceptable plan. You still accept your punishment.

   Al or Ann, CCW

   Same situation as above, but this time you elicit Willie's explanation and together you come up with the alternative of Willie seeing the guidance counselor at school to find a different gym class. You agree to work with Willie if that plan isn't feasible.

SECTION III: LIFE-SPACE INTERVIEWING

BEHAVIORAL OBJECTIVES

At the end of this training session, participants will be able to

1. List and define the following six components of life-space interviews:

   - isolate the child from the problem situation
   - hear the child's view of what happened
   - explore alternative views
   - develop insight about how the incident fits into child's pattern of behavior
   - develop alternate behaviors for child's self-expression
   - reintegrate child into activity or program

2. Demonstrate their ability to use the life-space process by developing a role play that includes all six of the steps of the life-space process.

3. Utilize the critique of participant observers to become more aware of the effect of their voice tone, body gesture, and body position on the child's perceptions and interaction.

BEHAVIORAL CHANGES

1. Workers will be more aware of their communication patterns and use such factors as gestures, posture, and facial expressions more consciously when conducting life-space interviews with children.

2. Workers will discuss their life-space interviewing efforts at child care and treatment team meetings. They will also include reports on their progress in using the technique in logs and other records.

3. Workers will be able to conduct effective life-space interviews with individual children.

230

RESOURCE PAPER: THE LIFE-SPACE INTERVIEW

Omitting the technique known as "life-space interviewing" would be a grave mistake in any discussion of child care treatment. It is a technique that has been developed from line child care work and, to some, is the essence of good child care practice. It may well be the only technique that has evolved directly from milieu therapy or residential group work. Child care workers have the advantage of being able to utilize their many contacts with children for the child's benefit. Unlike the social worker, psychiatrist, or psychologist, who has a therapeutic hour, the child care worker has the "other twenty-three hours" to reach the child. Every conversation can serve a purpose within the child's treatment, and the life-space interview can make giant steps towards the end goals.

Let's dissect the label. What is "life space"? The phrase refers to the whole complex array of situations and places in which the children in residential care live: the dining room, bedrooms, bathrooms, on-grounds school, playground, other children, and all of the staff. Fritz Redl coined the phrase life-space interview to indicate that the technique he was describing was one that is to be used within the context of the child's activity, as opposed to one used within the formal therapy interview.[1] The kind of interview that we are discussing deals with issues and actions being played out within the flow of the child's daily life.

What about "interview?" Simply put, this refers to a give and take conversation with the child about an issue that is of concern to him and the worker at the moment (e.g., Johnny's constantly teasing another child in the living unit). However, this is too simple. The conversation is not an aimless one; it can have several goals, some of which will be examined later in this paper.

Life-space interviews are conducted by a person perceived by the child as part of his or her life space with a clear role and power in his or her daily living environment, in our case, a child care worker. Life space interviews contrast in many ways with traditional interview techniques found in clinical social work practice. The classical approach would be that reality issues (everyday life events) should be handled only when they endanger therapy. However, the life-space approach specifies that "with severely ego-damaged children [these events] provide some necessary materials without which therapy could not go on."[2] Traditional and life-space techniques complement each other; both need to be used with the same child. Often issues that come up within the milieu are touched on again by the social worker or psychiatrist.

Life-space interviewing skills are designed to be used with the child whose low ego development results in numerous outbursts and behavior disturbances throughout the day. When a child care worker decides to intervene in the problematic behavior of a child, he or she needs to decide what the objective is in doing so. He or she may have a short-range goal of merely cooling things down by offering support to a child in crisis, or he or she may wish to intervene with a more long-range goal in mind, such as helping the child see how his or her behavior in this incident is similar to an ineffective pattern the child uses at home with his or her parents.

A worker's ability to make this judgment is dependent on many factors, as are all other child care techniques. It depends upon the child, the situation, the worker's relationship with the child, and the worker's comfort both with the content of the interview and with the child. Most important, it depends on the team's treatment goals for the particular child. A written treatment plan outlining the areas the child and staff are working on and which methods are to be used is very helpful in keeping a team consistent and effective.[3] For example, a life-space interview is to be used when Jim is involved in sex play with another child to help Jim see how this behavior affects the other child and how it may be inappropriate in terms of what Jim is actually trying to express. This plan specifically cues a worker into Jim's behavior, which needs a more in-depth approach. The worker could also approach the behavior less intensively; when Jim is involved in sex play with another child the worker could suggest to Jim that there are other activities going on that Jim might like and that the worker would like Jim to join the rest of the group. Both plans would be acceptable, depending on the dynamics behind the behavior and the worker-child relationship.

Redl has divided life-space interviews with short-range goals and those with longer-range goals into the following categories: "emotional first-aid on the spot" and "clinical exploitation of life-events."[4] Sometimes a child care worker can be very clear about which of these approaches to use; at other times this is impossible to know ahead of time; and sometimes it is necessary to switch from one to the other midway through the interview. A worker must be sensitive to the interaction. The key is flexibility and preparedness. On one occasion a child may be willing to talk about a significant dynamic within his or her life, and on another he or she may only need support from the worker to get through a tough spot.

Let's elaborate further on Redl's terminology of life-space functions. "Clinical exploitation of life events" involves directing the interview with a child toward the relation between the immediate situation or action and a long standing pattern of behavior that the child and staff are attempting to change. The purpose is to point out to the child the relationship, to help him or her see it, to stimulate insight, and to provide him or her with the chance to change negative ways of dealing with his or her life and other people. The goals here are often long term. On the other hand, "emotional first-aid on the spot" aims to help the child handle the demands of daily living. The worker provides the support for the child to manage the feelings associated with his or her actions in the here and now. The goals are short range.

Redl breaks these two functions into subfunctions. He points out that his list is not meant to be exhaustive, only illustrative. A brief outline will be given here to highlight these categories. Under the function of clinical exploitation of life events he lists with his characteristic humor:

1. Reality rub-in: A worker attempts to explain to the child the meaning of events in which the child gets involved. Because of developmental lags or emotional reactions, children-in-care often are confused by or distort what goes on around them.

   Example: The child interprets every worker's action as an attempt to dominate the child or other children. The child needs to begin to see worker actions in a positive light by connecting them to the resulting benefits.

2. Symptom estrangement: The worker attempts to help a child see that the gain he makes with certain inappropriate behavior is not worth the losses that he incurs.

   Example: The child who holds onto babylike ways of acting (slurred baby talk, a toddler's walk) in order to get attention from others needs to see that he isn't gaining as much of what he wants (love), but instead he is turning others off.

3. Value repair and restoration. The worker attempts to help a child balance his values with his behaviors.

   Example: The child (or group) who blames another child for always stealing needs to realize that this is unfair scapegoating when it is shown that the other child isn't always the guilty party. In fact most of the kids in the unit might have stolen from one another.

4. New tool salesmanship. The worker attempts to teach the child a variety of more-appropriate-to-life situations.[5]

   Example: The child who always fights to solve any disagreements in which he finds himself can be taught more constructive ways to settle disagreements.

5. Manipulation of the boundaries of the self: The worker attempts to help the child "learn effectively where he ends and other people and/or their rights, privileges, and processes begin."[6]

   Example: The child who easily "catches," i.e., continues another's mischief or aggression, or who forces his own feelings, whims, or prejudices onto another child, needs to learn how to be his own person.

When Redl discusses emotional first-aid on the spot he also lists subfunctions.

1. Support during moments of frustration: The worker helps the child drain off his frustration and hostility when a pleasurable activity or feeling is interrupted.

   Example: The child who blows up when he can't continue playing his favorite game may need the worker to remind him of the other opportunities he will have the next day to play.

2. Support during moments of panic, anxiety, guilt, and fury: The worker needs to help the child focus and put into perspective his feelings when he is overwhelmed.

   Example: The child who is consumed by rage when his parents leave after a visit may need the worker to reassure him that he is not being abandoned and that they will be back.

3. Support in moments of relationship decay: The worker needs to maintain communication with the child who is breaking off all communication and retreating into an autistic world of fantasy.

   Example: The child who flips out when threatened by another child in the unit and runs to his room where he sits silently looking off into space.

This completes Redl's view of the life-space interview. For a more in-depth presentation readers are advised to consult David Wineman's "The Life Space Interview" as well as Redl's own writings. The references follow this article.

We have discussed many reasons why and when a worker would use life-space techniques with a child. A worker's expertise in deciding when to intervene (timing is crucial), who should speak to the child (that is often simple, but not always), what should be emphasized, what should be left untouched, and where the interview should take place improves only through long-term exposure to the child and development of a relationship. We can, however, look at components that loosely outline how to conduct a life-space interview. (Here "component" is being used to refer to steps the worker might actually take. It is not being said that every component described must always be used, or that they are to be used in the order presented. Clearly, it is not always possible to do all of them. Later in the paper the interview is examined as having a beginning, middle, and end. Again, these parts and their component steps are used to picture a goal one can aim at in practice, rather than what each and every life-space interview must look like.)

The components in the process are:

1. Isolate the child from the problem situation.

   This is done to stop the behavior, to avoid further contagion from the environment or others present, to provide privacy and often safety for the child, and to allow the worker to give the child his undivided attention. Metaphorically, it can be viewed as the worker putting parentheses around the child's activities for a brief period. If the staff member is the only one with the group, he may need to stop the behavior and wait for a more appropriate time to talk in more depth with the child. Also, he may decide that the time is inappropriate because it is out of routine or the child is not receptive. For example, with the child who acts up at midnight it might be better to stop his action and pick up a conversation the following morning, when both he and the worker are less fatigued.

2. Hear the child's view of what happened.

   It is wise to be open and receptive to the child's perception of what happened. The child will only talk honestly if he can trust the adult, and none of us trust others who already have a closed attitude about us. Hear him out. Workers do not always know what happened and often, like detectives, need to piece together many clues in order to find out what indeed did transpire. Even if the child is distorting reality, the worker must listen so the child knows he will be heard.

3. Explore with the child alternative views of what happened.

   The worker is now free to share with the child either what he perceived as happening or what another person who was present has reported. At this point there may be some discrepancy between everyone's perceptions and the worker will need to search further into the alternatives to clear it up.

4. Help develop insight about how the incident fits into the child's pattern of behavior.

   It is very important to help the child understand why he is behaving in a certain manner. This insight will alert the child when he falls into a repetitive pattern of responses. For example, a child would need to know that he usually ends up fighting whenever he plays with a child bigger than himself, and at these times he is feeling very scared. This insight is helpful to him in preventing the problem behavior. It provides him with a clue to what will happen if he continues his actions. He may also develop insight into patterns that started in his past, and how maladaptive these actions are to achieving his goals. He will then be more open to substituting successful patterns of behavior.

5. Develop alternative behaviors for the child's self-expression.

   A sensitive worker can help a child realize that his feelings are legitimate, but that his actions are counterproductive and inappropriate. It is important for the child to know that when he is feeling this way he can choose from a variety of alternative responses. The worker and the child together can brainstorm other approaches to the problem. It's imperative for the child to agree that the substitute behavior is worth trying and that he is satisfied with it.

6. Reintegrate the child into the activity or program in which he was previously involved.

   Helping a child pick up the pieces or resume his normal activity or routine is also part of the worker's role in a life-space interview. The child and worker can have a sense of closure without lingering tensions. A sense of moving on and continuing the relationships between all parties involved is accomplished.

These components can be divided into three phases. Components one through three are the beginning phase. This may be the period that takes the longest time, as the worker explores all of the variables in the situation. It is also a cooling down period that helps the child recuperate from the disruption. It is possible that a life-space interview could stop at this point. A short-range goal might be merely to stop a child's behavior and have him begin looking at it from the perspectives of all those involved. A worker might do this with a child he doesn't know well, a child who is new to the program, or a child with a less serious behavior problem.

The middle phase encompasses components four and five. This is a more in-depth view of the behavior that goes beyond the here and now. This phase is tied in with long-term treatment goals that require the child to change his behavior and to incorporate the new behavior into his pattern of life. To reemphasize, it is possible that many interviews consisting of components one to three must take place before the worker is able to include the remaining steps with a child. For example, a child may need to discuss the facts around his stealing many times before he and the worker can deal with why he is stealing, and what other more appropriate behavior might satisfy this need. If the worker and child know each other well and have had many interactions regarding this behavior, they will be able to utilize all six components; in fact, the time needed to get through the beginning will be decreased. For example, Sally and the worker have talked so many times about her breaking curfew that they merely touch on what happened and how everyone views it and quickly go on to how she could talk to a staff member about feeling scared about sex on dates and what she can do about it.

The sixth component, the ending phase, should always be included, no matter how many steps have been completed. It is essential to help the child continue within the milieu and to feel a sense of resolution at least for the present time.

These components have been presented as a general guideline for conducting a life-space interview. The hope of the author is that child care workers will use the opportunities through daily conversations to intervene therapeutically with children in care. They can neglect those opportunities and merely be custodians who supervise the child's day; or they can, by using those opportunities, have great impact on the child's life as agents of change.

References (see pp. 243-44 for full listings)

1. Fritz Redl, "The Life Space Interview - Strategy and Techniques," in *When We Deal with Children*, pp. 35-67.

2. David Wineman, "The Life Space Interview," in *Children Away From Home*, edited by James K. Whittaker and Albert E. Trieschman, p. 238.

3. See "Section I: Goal Planning" of this module.

4. Redl, pp. 239-240.

5. See Section II of this module where teaching alternative behavior is dealt with in detail.

6. Redl, p. 247.

SESSION OUTLINE: LIFE-SPACE INTERVIEWING

Time: 2 hours, 20 minutes (3 hours if certain suggested alternate activities are used)

Space: A room large enough for participants to break into corners for role playing or a large room plus 3 or 4 breakout rooms

Equipment: Easel pad and stand (or blackboard); markers
Optional (for alternate strategies): video player/recorder, video monitor, 16 mm movie projector, screen

Materials: Handouts
- "Conversations of the Right Kind," p. 249
- "Common Errors in Communication," p. 250
- "Nonverbal Language," p. 251
- "Six Steps of Life-Space Interviewing," p. 253
- "Life-Space Incidents," p. 254
- "Life-Space Interviewing Feedback Sheet," p. 255
- "Rules for Giving Feedback," p. 256
- Optional (for use with movie): "'Can't You Understand What I'm Trying to Say?'" p. 257

Optional (for alternate strategies): videotape of a life-space interview; the movie Can't You Understand What I'm Trying to Say?

1. Warm-up 20 minutes

Using a flip chart, blackboard, or individual handout, the trainer gives the following directions: Think of one thing from your past (a person, place, situation, etc.) that has had the most positive influence on the way you believe, think, feel, and act. Be prepared to communicate that "thing" to the group by either

a. acting it out nonverbally, or

b. pretending that you are that person, place, or situation and describing yourself to the group. (Example: Your parents worked for a carnival. You might say, "I am crowds of people, cotton candy, noises, the smell of hot dogs, etc.") The rest of the group must guess what you are presenting. The trainer should give the participants two or three minutes to prepare themselves, then ask for a volunteer to start; or the trainer may wish to start first to give everyone the idea. As soon as the group guesses correctly for each person, he or she may sit down. The trainer should conclude the warm-up by pointing out that each of our communication patterns is influenced by experiences, people, situations, values, and so on from our past, as well as by our present environment and role definitions.

2. Introduction 5 minutes

At this point the trainer should list the objectives for the session and introduce the life-space interview with the following definition:

> The life-space interview is on-the-spot therapy that helps the child understand and cope with what is happening in his life space at that point.

The trainer may wish to ask if anyone has anything to add to this definition.

3. The Life-Space Process 45 minutes

a. The trainer should have someone help him or her do a role play of a life-space interview (15 minutes). The trainer should prepare this with a partner ahead of time. The role play can purposely include only half of the six components of the life-space process.

Alternate Strategy: Rather than perform a role play on the spot, the trainer may wish to use a videotaped role play of a life-space interview. The videotaped role play could include all six components and thus be utilized as a "how to" demonstration, or it could include only some of the six steps and be used for discussion purposes.

If the videotaped example is complete, the tape should be played through once, then replayed during a discussion, stopping to point out each step.

If the videotape only includes some of the life-space steps, the trainer may process the videotape in the same way as directed below.

b. After the role play (live or on videotape) the trainer should lead a discussion of it by posing questions such as the following:

- What things did the worker do well?
- What things did the worker leave out that should have been done?

The processing of these two questions should result in a list that includes the six components of the life-space interview (see resource paper, pp. 232-34). The trainer should also ask for comments on the use of nonverbal and verbal messages, e.g., were there any incongruencies between the verbal and nonverbal messages? If so, what were they? Again, list examples and include additional information from the resource handouts on verbal and nonverbal communication ("Conversations...," "Common Errors...," and "Nonverbal Language"), which can be given out at this time. Summarize the presentation of the life-space process by distributing the handout "Six Steps of the Life Space Interview."

4. Practicing the Life-Space Interview 60 minutes

At this point the group should be divided into groups of four either randomly (counting off) or by choice. The trainer distributes the handouts "Life-Space Incidents," "Life-Space Interviewing Feedback Sheet," and "Rules for Giving Feedback." The following directions should be given:

- Noting that the four incidents represent different ages, sexes, and issues to be dealt with, take a couple of minutes to choose one incident to role play.

- Two members of a group will do a role play (one playing child, one worker) while the other two act as observers, utilizing the feedback sheet.

- Each person should have a chance to play the worker role and each should try to include all six components of the life-space process within the role play.

- Groups should probably set a time limit of 10 minutes per role play to allow for feedback from each person.

Before dispersing into the small groups the trainer should instruct the participants to read the "Rules for Giving Feedback" and discuss any questions about them. Trainers should circulate to all small groups while life-spacing skills are being practiced to be available for answering questions and giving input and encouragement.

Alternative Strategies for Practicing Life-Space Interviewing:

a. The trainer may suggest that participants utilize an incident from their own daily experiences at work for the role play. This is especially applicable when the training group is composed of a cottage team or an in-service group who deal with the same types of children in the same environment.

b. Or, if the participants are not familiar with each other, the trainer may wish to provide them with a common experience. Here the movie Can't You Understand What I'm Trying To Say* can be shown and the handout of the same title can be used as a basis for the role play.

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* Available from Child Welfare League of America, 67 Irving Place, New York, N.Y. 10003. Some county departments of social services own copies of this film. Contact the staff development coordinator at your county DSS.

Incidents would be chosen from the incident list and role plays with feedback would proceed as directed in the original strategy described above. Naturally, the length of the training would be increased by the length of the movie (30 minutes).

Alternate Strategy for Role Play Feedback (based on first practice described):

Participants can be videotaped while role playing a life-space interview. The videotape, a trainer, and a feedback team are then all used for feedback. This is an excellent teaching device, as participants get an unbiased picture by actually seeing themselves enacting a life-space interview.

However, if this device is to be used, the training group must be small (6-8 people) and ample time must be allotted so that each participant has time to observe a complete playback of his role play and there is time for feedback from observers. Also, if videotaping on the spot is to be used, additional warm-up exercises may be needed to reduce the anxiety produced by having to perform in front of a camera. The trainer must create a safe environment so the participants can use the experience. The tape must be for the individual worker's use only.

5. Wrap-up 15 minutes

Call the group back together and summarize by asking each participant to write at least one "I learned statement" about each of the following:

a. my communication pattern
b. issues with children that are easy for me to deal with
c. issues that are difficult for me to deal with
d. the step in the life-space process that I find most difficult
e. the step I would like to work on improving

Allow 5 to 10 minutes for each participant to respond personally in writing to the above.

Ask if anyone would like to share their statements with the large group. If not, that is OK.

Alternative Wrap-ups

1. The trainer may ask a team that has done an exceptionally effective role play if they would like to present a life-space interview to the larger group as a summary demonstration of the life-space process.

2. "Academy Awards" may be given by the trainer who has been circulating throughout the practice session, e.g., for best nonverbal performance, most supportive role, etc. Use your imagination. This is fun and provides both a tension release and a positive feedback for hard work done by all participants. It's really fun if you have videotape equipment and can tape the giving of the awards. The session is lengthened by the "awards," but in a very enjoyable way.

ANNOTATED BIBLIOGRAPHY

Bettelheim, Bruno. *A Home for the Heart*. New York: Bantam, 1975.

Although the children described in this book are severely disturbed, autistic children, Dr. Bettelheim's psychoanalytic descriptions of the important messages conveyed by physical settings, choice of color schemes, provision of private areas, etc., have wider application. His exceptionally clear description points up the importance of planning therapeutic surroundings. See especially chapters 9, 10, and 15.

——— and Sylvester, Emmy. "A Therapeutic Milieu. "*American Journal of Orthopsychiatry* 18: 191-206.

In this article, the authors present two case histories and stress how one of the essential components of a therapeutic milieu, the relationship between child and worker, can be a therapeutic tool.

Children's Defense Fund. *Children Without Homes: An Examination of Public Responsibility to Children in Out-of-Home Care*. Washington, D.C.: Children's Defense Fund, 1978.

A study of the foster care systems of seven states (New York is not included), documenting the problems and inequities inflicted on children and families, this work provides the child care worker with a national perspective and inspiration to continue advocacy for the child. It also alerts the reader to carefully examine policies to be sure that children and families "count."

Fanshel, David. "Parental Visiting of Children in Foster Care: Key to Discharge?" *Social Service Review* 40, no. 4 (December 1975).

Although this article's title relates to another module's subject matter, it is also pertinent here. Fanshel includes analyses of several variables and measures their correlation with the length of children's stays in the foster care system as a whole. In structuring goals for children in residential care, child care workers and other members on the treatment team will find these analyses significant. An important article.

———. "Status Changes of Children in Foster Care: Final Results of the Columbia University Longitudinal Study." Child Welfare 55, no. 3 (March, 1976).

Another important contribution by Fanshel summarizes the findings of a lengthy and detailed study of children in the New York City foster care system, including residential institutions. Again, those setting goals for children in care will find useful information here.

Ginott, Haim. Teacher and Child: A Book for Parents and Teachers. New York: MacMillan, 1972, Chapter 4, pp. 79-123.

A delightful, down-to-earth book about relationships between teachers and students. Basically, everything that is discussed could be placed under the heading of the relationship between the child care worker and child. Ginott gives some clear advice on talking to children. Many of his guidelines are common sense, good manners, and sound therapeutic practice. However, we all at times get lost in our everyday dealings with others. He provides us with a check list for reappraisal of our communication skills on the job and in our personal lives.

Klein, Alan. The Professional Child Care Worker. New York: Association Press, 1978, Chapter 6, pp. 69-89.

Klein gives a basic framework for a communication model between sender and receiver. He reviews concepts such as noise, decoding, nonverbal communication, feedback, congruent and noncongruent communication. He also examines communication patterns in an institution specifically and asks the reader to explore his own skills in this environment.

Long, Nicholas; Morse, William C.; and Newman, Ruth G. Conflict in the Classroom: The Education of Emotionally Disturbed Children. Belmont, Calif.: Wadsworth, 1976.

The literature and research of special education are long-neglected resources for child care work. While the roles of CCW and teacher are obviously not the same, there are important parallels and overlapping tasks. This anthology is a fine introduction to the field. It contains excellent, fascinating selections grouped under the rubric "How Does It Feel to Be Emotionally Disturbed," and equally excellent readings on various other significant issues, including life-space interviewing. Especially noteworthy is the "Worksheet on Life-Space Interviewing for Teachers," by William C. Morse, pp. 337-342, which is reprinted in Residential Child Care: A Reader, Anne Stea, ed., Continuing Education Program, School of Social Welfare, State University of New York at Albany, 1979, pp. 68-75.

Mordock, John. "Evaluation in Residential Treatment: The Conceptual Dilemmas." Child Welfare 57, no. 5 (May 1979).

This article discusses some of the difficulties in evaluating treatment programs on the agency level, but the reader can easily see the relevance to the planning of goals for children and evaluation of the outcomes. Major emphasis is placed on the importance of knowing what the goal is - i.e., specific goals with specific time frames - before trying to measure success or failure.

New York State Department of Social Services, Administrative Letter 100. Albany, N.Y.: September 27, 1976.

This document contains New York State's regulations on case planning for children placed in foster care, including residential care, that have the overall purpose of preventing unnecessary or unnecessarily prolonged separation of a child from the family. The regulations took effect January 1, 1979. Short-, intermediate-, and long-range goals are defined; and several other important topics are addressed. Of special note to child care workers is the requirement that the social worker assigned to a child's case obtain information about the child's adjustment "through personal contacts with those immediately responsible for his day-to-day care" (pp. 7-8).

New York State Department of Social Services. Uniform Case Recording Standards: Casework Manual. Albany, N.Y.: January 1981.

In 1979 the Child Welfare Reform Act made far-reaching changes in the foster care system in New York State. One such change was the creation of a Uniform Case Record (UCR) for recording case information, service plans, etc. The UCR manual incorporates the ideas and principles contained in Administrative Letter 100. Where the two documents differ the manual supercedes the letter. The UCR itelf went into use as of April 1, 1981, and became the most significant set of documents in any child's case files, since it contains assessment information as well as the overall service plan.

Redl, Fritz. When We Deal with Children. New York: Free Press, 1966.

This excellent collection of articles contains a wealth of important information, written by one of the foremost pioneers of professional child care. Two articles are especially important for this module: "The Concept of a Therapeutic Milieu" and "The Life-Space Interview - Strategy and Techniques." Both articles contain fine illustrations and important explanations.

Szasz, Suzanne. *The Body Language of Children*. New York: Norton, 1978.

Suzanne Szasz is a photographer and psychologist who has combined these two interests to present a sensitive and beautiful interpretation of the body language of children.

Through a series of photographs and interpretive narrative, she presents the basic emotions: happiness, sadness, disgust, fear, hostility, love, etc., as expressed nonverbally. Individual body parts are also given focus, e.g., eyebrow, shoulders and hand language. A section on the effects of parents' body language on children is also included. This book is a must for any parent, teacher, or child care worker, since it opens the reader's eyes to the importance of nonverbal communication in children and to the importance of congruence between verbal and nonverbal messages of adult role models.

Trieschman, Albert E.; Whittaker, James K.; Brentro, Larry K. *The Other 23 Hours*. Chicago: Aldine, 1969.

This book is *the* introduction to therapeutic child care work. It contains essential information on the therapeutic milieu and teaching alternative behaviors, as well as several other significant child care tools. The writing is clear and explicit without being jargonistic or pompous. The examples are to the point and child care oriented. A must for any professional CCW.

Whittaker, James K., and Trieschman, Albert E., eds. *Children Away From Home: A Sourcebook of Residential Treatment*. Chicago: Aldine, 1976.

This anthology contains many good articles on a variety of issues in residential treatment.

Wineman, David. "The Life-Space Interview." *Social Work* 4, no. 1 (1959): 3-17.

In this article, Wineman illustrates the various strategies of the life-space interview with lengthy transcripts of real dialogues. These interviews give a real flavor of the use of the technique. (Reprinted in Whittaker and Trieschman, *Children Away From Home*.)

HANDOUTS

SELF-ASSESSMENT: CHILD CARE PRACTICE

You can measure the effect of training on your professional activity by using this form. Also, the trainer can use your responses to evaluate - and improve, if need be - the training. So please be as honest as you can in your responses.

In the boxes below, respond to the following items. Answer "yes" or "no" to the parts of (a); use the number on the scale that most closely represents your level of activity for each of the other items. Repeat this process at three months and six months after training.

a. I know (1) the five steps of goal planning; (2) the categories for describing problem behaviors; (3) the criteria for short-, intermediate-, and long-range goals as defined by Administrative Letter 100; (4) the three steps of teaching alternative behaviors; (5) the six components of life-space interviewing.

b. I make it a point to write specific goals for each child I work with.

c. I make it a point to use a set of categories to describe problem behaviors fully before attempting to change them.

d. I make use of the technique of teaching alternative behaviors when appropriate.

e. I make an effort to exploit life-space interviews to the fullest by trying to include as many of the six steps as are appropriate.

1	2	3	4	5	6	7	8	9	10
never		occasionally		sometimes			often		always

	a. Knowledge items	b. Writing goals for each child	c. Categories for describing behavior	d. Teaching alternative behaviors	e. Life-space interviews
1. Before training	1 2 3 4 5				
2. Three months after training	1 2 3 4 5				
3. Six months after training	1 2 3 4 5				

Of course, if your knowledge of and use of the techniques described in these sessions does not increase, something in the training can be improved. Please share your thoughts on this with the trainer.

FIVE STEPS OF GOAL PLANNING

Step One: Defining the behavior to be changed

1. Time: When the behavior typically occurs - bedtime, free time, after school, etc.
2. Frequency: once a day, once a week, once an hour.
3. The people involved: CCW, teacher, peers.
4. Mode and pace: physical, verbal, or both; slow, driven, aimless, violent.
5. Developmental level: what developmental task is the child involved in through the behavior.
6. Defense mechanisms: avoidance, denial, repression, projection, rationalization.

Step Two: Translating the problem behavior into a specific goal.

Be sure to be realistic about the time frame you use to make a goal short-range (three months), intermediate (six months), or long-range.

Step Three: Determining the cause of the behavior.

What are the dynamics behind the behavior? Defense mechanisms, developmental stages (see step one), stages of loss and separation, family dynamics.

Step Four: Choosing the appropriate child care method.

Decide on child care method that will help achieve the goal. What CCW method/technique? Do you utilize relationships (staff, peers, family, volunteers), group processes, activity programming, community resources, behavior modification, confrontation, support or a nondirective approach, etc.?

Step Five: Evaluating the change in behavior

What are the ways to measure success? What are the criteria? They should be time-focused and easily observable, measurable not only to staff, but to the child and his family. A system of review and re-evaluation are important. If goals are not being met, then it is necessary to revamp or eliminate them.

JOHNNY JONES

Pinehurst Center is a closed residential setting for delinquent boys, ages eleven through seventeen. Residential capacity is sixty boys, who are divided into four cottages, each with fifteen.

Pinehurst's treatment method is modeled on a combination of reality therapy and behavior modification. The boys begin with no privileges and are rewarded with more freedom as their behavior meets established expectations. The court placement period is generally for one year. This may be extended in special circumstances.

Johnny Jones is a sixteen-year-old male, adjudicated delinquent six months ago. He was placed at Pinehurst because of a long record of previous offenses. His last offense involved a stolen car and a police chase. Other activities in which he has been involved are stealing, truancy, street fighting, and possession of marijuana. He was involved with a group of delinquent boys but had no close friends.

Johnny's mother is thirty-eight. His father's whereabouts are unknown. His mother has raised him and his older sister with some input from different boyfriends. She gets very upset when Johnny gets into trouble and says he's just like his father. She declares that she doesn't know what's wrong because she has tried her best. She is unable to see that any intervention at this point would keep him from ending up in jail. Mrs. Jones has no close friends or family and has had a series of boyfriends. However, she has had much difficulty in sustaining any long-term relationship. Johnny has never gotten along with his mother's boyfriends.

Upon placement, Johnny was sullen and rebellious but not violent. He began to make some adjustments, but for no apparent reason he recently attacked a male child care worker with a knife. The worker was not injured and after some commotion, Johnny was subdued. The social worker reports that he has talked of feeling trapped and has toyed with the idea of suicide.

He has made no friends. His mother has not made any effort to visit him, and he has not tried to get in touch with her.

At times, Johnny can be most charming and seems to comply with the staff. He has not, however, opened up to anyone at Pinehurst.

It has recently been discovered that there is an extortion ring of which Johnny is suspected leader.

CONVERSATIONS OF THE RIGHT KIND

DO

1. Grant in fantasy what cannot be given in reality
2. Change moods rather than minds
3. Use "you" messages in responding to child's plight, complaint, or request
    - a. It accurately acknowledges the child's statement or state of mind;
    - b. It does not deny his perception;
    - c. It does not dispute his feelings;
    - d. It does not disown his wishes;
    - e. It does not deride his taste;
    - f. It does not denigrate his character;
    - g. It does not derogate his character;
    - h. It does not degrade his person;
    - i. It does not argue with his experience.
4. Be authentic
5. Speak to the situation not the child's personality and character
6. Use "I" messages to describe what you feel about what a child does
7. Provide opportunities for independence ("What options are open to you?")
8. Use ego inflating messages

AVOID

1. Diagnosis (labeling) and prognosis (doom predictions)
2. Commands (this increases defiance)
3. Fragmenting and multiplying demands
4. Whys?
5. Put-downs - ego destructive messages

Adapted from Haim Ginott,
Teacher and Child: Book
for Parents and Teachers
(New York: Macmillan, 1972)
Chapter 4.

COMMON ERRORS IN COMMUNICATION

1. Not listening
2. Answering before the sender finishes
3. Interrupting
4. Not replying to what was said
5. Deliberately misunderstanding
6. Replying to a stereotype rather than an individual
7. Dropping one's voice at the end of a sentence
8. Never finishing a sentence
9. Jumping from idea to idea without connecting words or phrases
10. Stringing unconnected thoughts together
11. Projecting one's feelings on the other

NONVERBAL LANGUAGE

*I. Many of our basic emotions are expressed through nonverbal rather than verbal means.

- a. WARMTH - touching, leaning, moving close to, and getting on the same level as the other person;
- b. FEAR AND ANXIETY - fully opened eyes, furrowed brows, downturned mouth, muscular tenseness, and biting lips;
- c. CURIOSITY - staring, leaning, touching, tasting, fingers in mouth;
- d. HOSTILITY - narrowed eyes, contracted brows, downturned mouths, raised hands;
- e. HAPPINESS - smiles, loose movements, in motion without hurrying, mouths curved upward, brows clear;
- f. UNHAPPINESS - sickness, thumb sucking, distant or vague look;
- g. ANGER - wrinkled brows, pursed lips, hunched shoulders, flailing arms and legs.

*II. Certain body parts are most often used in expression and usually have the following interpretations:

- a. EYEBROW LANGUAGE
  1. 1 up = disbelief
  2. 2 up = surprise
  3. 2 down = suspicion, mistrust

- b. SHOULDER LANGUAGE
  1. 1 raised = I don't know or I don't care
  2. 2 raised = fear
  3. squared = determination
  4. lowered, rounded = sagging under a burden

- c. HAND LANGUAGE
  1. point accusingly
  2. palms up = begging or questioning
  3. fist = tension
  4. folded arms = protection
  5. scratching head = confusion
  6. covering eyes or ears = shutting out

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* Adapted from: Suzanne Szasz, The Body Language of Children (New York: Norton, 1978).

III. Every body part has the potential for sending a certain message.

a. HEAD - erect, hanging, or bowing
b. MOUTH AND JAW - teeth, smile
c. VOICE - rapid, whiny, choked, soft
d. EYES - wink, squint, lowered
e. NOSE - flared nostrils, wiggle, exhale
f. NECK AND SHOULDERS - shrug, tightness, rounded
g. ARMS - hug, wave, lean
h. HANDS - fist, hide, reach, push
i. TORSO - breathing
j. LEGS AND FEET - stamp, kick, closed
k. TOTAL BODY - open, erect, loose, stiff, squirmy
l. AUTONOMIC - sweating, pale, blushing

IV. Nonverbal cues reveal how rigid or flexible, open or closed, approachable or rejecting, free or limited, secure or self-protecting, cooperative or directive a person is.

SIX STEPS OF LIFE-SPACE INTERVIEWING

The life-space interview is a term coined by Fritz Redl. Briefly, Redl would define the life-space interview as the process of taking a child aside to discuss problematic behaviors where and when they occur. This process involves six steps:

A. Isolate the child from the problem situation: Remove the child from the place where the problem behavior took place, e.g., by breaking up a fight and taking the child to another room or taking the child away from the bedroom where he/she was involved in sex play.

B. Hear child's view of what happened: Really listen to the child's complete description of what happened, without interrupting, whether or not you believe his/her version. This is the first step toward establishing trust.

C. Explore alternative views of what happened: Tell the child what you saw or heard or what another child or some other observer may have reported. This is the time to show the child that there may be some discrepancy between what he/she feels really happened and what others see. This is often the first step of getting at denial, scapegoating, etc.

D. Help develop insight about how the incident fits into the child's pattern of behavior: You might say, "Every time you lose a game you seem to get very upset and usually accuse others of cheating, etc." or "I can see your face get red and notice you biting your nails every time your mother calls." Here you must try to help the child see what the warning signals are for many of his outbursts or depressions, etc. The purpose of this step is to help the child see where and when he/she must learn to intervene in his/her own behavior to prevent behavior that really gets him/her in trouble.

E. Develop alternate behaviors for child's self-expression: Try to help the child find different ways to express the same feeling, i.e., "When you are mad at Joe you could punch your pillow or write a nasty letter instead of hitting him." It is good to ask the child to think of some of his/her own alternatives.

F. Reintegrate child into activity or program in which he was previously involved: Simply take the child back to where the problem occurred, i.e., if he/she tipped over a game table take him/her back to pick up the parts, either helping the child or not. This step is very important as it helps the child face responsibility for his/her own behavior and helps prevent leaving a traumatic or tension-filled experience unfinished or unresolved.

LIFE-SPACE INCIDENTS

No. 1 Nicole, 15, is baking a cake when Joan enters the kitchen. When the cake comes out it has fallen. Nicole throws the cake on the floor and starts yelling at Joan, saying it's all her fault, threatening her, etc.

TREATMENT GOAL: Improve self-image so child can accept responsibility for her own actions, failures, etc.

No. 2 Bill, 16, is playing Monopoly with three other boys. All of a sudden he throws the Monopoly money all over exclaiming that nobody knows the rules except him!

TREATMENT GOAL: Child needs to develop a positive relationship with at least one other child.

No. 3 Diane, age 9, asks to stay out and play longer when the worker says it's time to come in for dinner. Diane, stamping her feet, threatens to run away, exclaiming, "You never let me do anything, it's not fair!"

TREATMENT GOAL: Child will act age appropriately.

No. 4 Eddie, age 7, comes into the cottage to use the bathroom and sees the afternoon snacks on the table. Although he knows his group is being called in for snacks, he takes several cookies and hides them in his room.

TREATMENT GOAL: Child needs to develop trust in the environment.

LIFE-SPACE INTERVIEWING FEEDBACK SHEET

A. Did the worker complete the following steps?

1. Intervene (stop the behavior).
2. Hear child's view of what happened.
3. Explore other views of what happened.
4. Help child develop insight about how the incident fits into the child's pattern of behavior.
5. Help develop alternate behaviors for child's self-expression.
6. Reintegrate (bring the child back into program).

B. Comment on:

1. What feelings are being expressed nonverbally:
   a. By worker
   b. By child
2. Is the worker's voice tone:
   a. Loud
   b. Soft
   c. Varied
3. Is the voice tone appropriate?
4. Is the worker's body posture and spatial distance appropriate?
5. Was the worker's use of verbal messages effective?
6. Were the verbal and nonverbal messages congruent?

RULES FOR GIVING FEEDBACK

1. Give undivided attention to the persons being observed.

2. Be descriptive rather than judgmental. Use nonthreatening, factual language.

3. Be specific rather than general. Describe specific behavior and incidents.

4. Deal with things that can be changed. Use statements that focus on things the recipient can change or control.

5. Give feedback when it is desired. Check and see if the recipient actually wants such information. Try not to go beyond point where the recipient is comfortable.

6. Keep your own experience out of the discussion. For example, "Last week, I did the same thing, etc."

7. Your motive should be to help the person practicing the technique to improve his or her skill by providing information about actions.

8. Try not to psychologize.

"CAN'T YOU UNDERSTAND WHAT I'M TRYING TO SAY?"

Case History

Marie, age seventeen, has been placed recently in an experienced foster family consisting of a father, mother, young son, and daughter. She has had multiple placements. Her caseworker, Mary, has noted patterns in each placement. Marie usually settles into the family but when faced with feeling close to them, she rejects and disrupts.

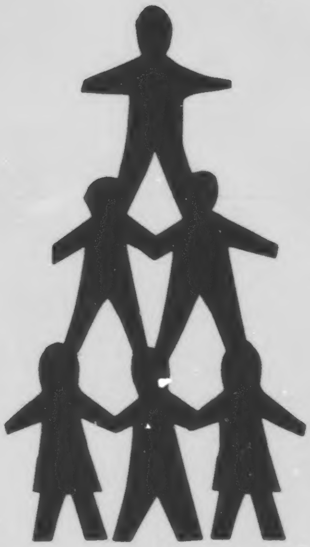
In addition to the stresses of separation, loss, and rejection, Marie faces the normal tasks of adolescence: physical maturation, heterosexual and peer relationships, independence, and identity formation. These tasks are illustrated by the following incidents from the movie: Marie deciding to live on her own, getting a job, budgeting her money, exploring sexual relationships, and experimenting with adult roles (drinking, smoking, etc.).

Life-Space Incidents

Assume that Marie was placed at your agency when she was fifteen. The treatment plan that has been developed includes helping her deal with past losses and preparing her for independent living. Based on your observations of Marie, your child care knowledge, and the treatment plan, formulate a role play of a life-space interview with her.

Choose an incident from those listed below.

1. Marie returns from a job interview disappointed by her lack of success. When another resident hassles her about it, Marie blows up verbally and storms to her room.
2. During a dance in the unit, a child care worker finds Marie and a guy in her room making out.
3. Marie doesn't have enough money to go to the movies with her group. She blew all of her allowance on an album. She is complaining to the CCW that allowances are too small.
4. Marie's best friend Sheila is being discharged to her home. Lately Marie is spending more time alone in her room listening to music and snacking constantly on junk food.
5. Marie returns from being AWOL and she has obviously been drinking.
6. Jeanne has been flirting with Marie's "boyfriend." Marie convinces the rest of the girls that Jeanne is a slut and not to be trusted.



Building Therapeutic Groups

by Anne Stea

INTRODUCTION

In 1977, the Child and Family Services Training unit conducted a child care training needs assessment. According to that study, one of the overwhelming needs of child care workers was more training on what to do with groups, how to use peer pressure, and, in general, how to make group living a more healthy experience for all children in placement.

As Dr. Alan Klein has stated in his book, The Professional Child Care Worker, the formation of therapeutic groups does not just happen. On the contrary, the formation of a therapeutic group living situation for children who come into placement with a multitude of problems is a complicated process that involves skilled planning and intervention by an entire team of child care workers.

If a feeling of safety cannot be established within a child's day-to-day living group, then all other efforts - individual counseling and family therapy included - will be ineffective. The child care workers' reply to our needs survey is evidence that they too realize the primary importance of establishing a safe and healthy group environment. It is in response to that stated need that this module on the child care role in building therapeutic groups has been developed.

The purpose of this module is threefold. First, it will demonstrate the CCW's need for understanding the dynamics of group living. Second, it will provide a knowledge base for understanding the basic function of the child care role in building therapeutic groups. Finally, it will acquaint child care workers with techniques and tools that they can develop and use to fulfill their role as primary group workers within the living unit.

BEHAVIORAL OBJECTIVES

At the end of the session participants will be able to

1. List at least two reasons why therapeutic living groups do not just naturally develop.
2. List the five basic child care worker functions necessary to developing a therapeutic living group.
3. Demonstrate their understanding of each of the five functions by describing at least one task that they perform or tool that they presently use or could use as a means of fulfilling each of them.

BEHAVIORAL CHANGES

1. Workers will communicate group mood and tone at shift changes.
2. Workers will involve children with leadership skills in helping other children learn athletic, craft, or other types of skills.
3. Workers will take time at team meetings to discuss inconsistencies that they may see between different staff members' enforcement of rules, disciplinary actions, giving of rewards, use of group activities, and so on.
4. Workers will spend more time keeping accurate records or log entries that specifically spell out the dynamics of each child's status within the group and how different children and incidents have affected the group mood on a daily basis.
5. Workers will develop more ways to instill individual and group pride, e.g., by giving rewards for most improvement as well as for best job.

RESOURCE PAPER: THERAPEUTIC USE OF THE GROUP

Salinger has aptly described the feeling that most child care workers have the first time they confront a crowd of angry, distrustful, disturbed kids:

> Thousands of little kids, and nobody's around - nobody big, I mean - except me. And I'm standing on the edge of some crazy cliff. What I have to do, I have to catch everybody if they start to go over the cliff - I mean if they're running and they don't look where they're going I have to come out from somewhere and catch them. That's all I'd do all day.[1]

Of course, one of the reasons why child care workers often feel this way is that the thousands of children who are sent to them do not know that they are supposed to act like a therapeutic group. The term therapeutic group is defined here as an instrument for the satisfaction of the needs of its individuals.[2] So how can we get a group of children, who bring with them many problems of their own, to form a support system that will be helpful to all of its members?

It is quite evident that a crowd of children does not develop into a therapeutic group spontaneously. Dr. Alan Klein has listed several reasons why children in placement have a difficult time developing real groups.[3] First of all, many children in placement, even though chronologically older, have not developed psychosocially beyond latency age. At latency age children have not yet developed to the level of group formation. They are instead involved in parallel play, in which they are interested in each other's presence and activity, but do not actively cooperate with each other.

Secondly, most children in placement are lacking in basic trust, the basis of group development. Closely related to the lack of trust is the fact that in residential placement the turnover is quite rapid; thus, in an attempt to avoid more emotional losses, many try not to get too deeply involved in relationships. A fourth factor is that to become a group member, one must give up some autonomy in yielding to group decisions. This takes a kind of self-discipline that many residentially placed children just don't have. Finally, one of the most common problems of children in placement is difficulty in forming positive interpersonal relationships.

In essence, group membership for most children within our residential facilities must become a part of each child's overall treatment plan. In order to facilitate successful group membership for each child, instead of just catching the child before he or she "goes over the edge of the cliff," the child care worker must perform several tasks.

Dr. Klein lists four general child care worker roles that are essential to building therapeutic living groups. They are: provider of safety, provider of relationships, provider of corrective experiences and hope, and observer.[4] I would amend this list by changing observer to observer-communicator, because observation by one worker of such things as group mood, tone, and norms will be of little use if not shared with other team members. I would also expand the list to include builder of awareness of staff team as a group. I believe that role modeling of cooperative and consistent functioning as a group is most basic to the formation of a therapeutic living environment.

Let us take a look at each of these child care functions in more depth. The order in which they are presented reflects the way in which the worker must deal with them in the residential setting.

Builder of Awareness of Staff Team as a Group

In order to facilitate the building of a therapeutic group, child care workers must provide a role model of a cohesive, positively functioning group. If there is unresolved conflict or inconsistency within the child care team, the children will be quick to recognize it. Different worker personalities and styles are inevitable within any residential child care unit, but these differences must not result in ambiguous and inconsistent enforcement of rules or a vacuum of relationship building. All workers on the child care team must make great efforts to communicate feelings, disagreements, and observations within the times allotted for team meetings and shift changes, rather than on the spur of the moment or in front of the children. Child care workers show respect for each other by making sure at change of shifts that all details about child interactions, problems, restrictions of certain children or certain behaviors, and so on, are communicated verbally and in writing, so that incoming workers will be able to make the transition and follow-through more easily. Where compromises concerning agency policy have to be made, this must be a team decision, not that of one individual.

The child care supervisor must set a tone among his or her workers that enables the expression of positive as well as negative feelings for one another and for members of other disciplines (psychiatrists, social workers, teachers, nurses, cooks, etc.) within the agency. Often a somewhat turbulent relationship develops between members of various professions and departments within the agency. Yet all of these people are working for the betterment of the child. If there is lack of respect and open communication between various departments, a unified direction cannot be given to the child. Often this lack of respect is caused by a lack of understanding about what it really is that the caseworker, or nurse, or child care worker does. An effective supervisor intiates meetings between staff of all departments to increase their knowledge of the details and goals of each other's daily functioning with the child. The whole agency must be able to function as a working therapeutic group, or the child will be able to play one subgroup against another and will learn that even adults can't trust one another, make group decisions, and function to meet each other's needs.

Observer/Communicator

There are three things that any child care worker must know about his or her group: the structure, the mood or tone at all times, and the norms and value systems. The worker should be able to use these three components to communicate problem areas and strengths or weaknesses to other members of the team. Let us look at these three areas individually.

Group Structure

Group structure includes status, role, subgroupings or cliques, and developmental levels of the individual children.

A child care worker should learn which children in the group have the highest status and which have the lowest. One way to determine this is by doing a sociogram of the group based on whom each child specifies as the person he would most like for a friend.[5] Another indicator of status is the control of information. The child who knows everything that is going on within the group usually has higher status. A worker should also be able to see which needs of a specific child are being met by his or her status within the group. For example, a child who has an extremely low self-concept may only be comfortable at the bottom of the pecking order.

Each child develops a role within the group. Basically, every group has leaders, followers, and isolates. Within any one of these role categories there are also certain unique roles, such as the "cottage lawyer" (the representer of the group conscience, the child who always says "That's not fair") or the scapegoat who takes the blame for any problem.

Group leaders are probably the easiest to pick out, but are not necessarily the easiest to deal with. It is with this role that child care workers often make mistakes. They often tend to use such leaders to do child care tasks, such as supervising cleanup or finding out who stole the cigarettes. Using leaders to do child care tasks can really put a child on the spot in terms of his value system! Which is more important - to be respected by peers or by the adults? If he uses his leadership ability to get peers to find out who stole something, then tells staff, he will no longer be trusted by his peers. Certainly, this kind of dilemma should not be fostered by a worker; it also represents an abdication of the worker's responsibility for controlling the group.

For an adult to compete with a child leader is even worse, since in this situation the worker has made himself a child. If he competes as a child and loses, the worker loses his image as an adult with a certain amount of authority.

There are ways, however, in which a child leader can be used positively. For example, a child who is unusually skilled at a certain sport or game can help teach those with little or no skill. The child leader is also a good choice as a team captain or committee head, because he or she will have more ability to instill pride and create enthusiasm. The important factor to remember is that the child should not be used to perform tasks that are beyond his or her developmental level. It is so easy to forget that the more sophisticated, mature group leader is not a miniature adult.

The worker must also be aware of the various subgroups or cliques that form within the group. Subgroups can form around common interests, strengths, or weaknesses. It is the clique that forms around a weakness or behavior problem that is of most concern to the worker, for subgroups like these can be very disruptive to the formation of the larger therapeutic group. The worker may want to set up special group therapy sessions for a clique that has formed around a problem, such as stealing or sexual acting out.

Group Mood or Tone

In this area the child care worker must develop a sort of eighth sense. As soon as he or she walks into the living unit, the worker should be able to sense the group mood or tone. Fellow workers can assist by communicating any occurrences that could have helped in establishing a certain group mood. The mood of a group of children living together is constantly changing, and many things affect it. A change in shifts, staff working styles, competitive activities, a child or staff person entering or leaving the group, intimidation (emotional, physical, or sexual), fights, therapy sessions, phone calls home, and school problems are only some of the everyday occurrences that can change the group mood.

The important question is, Who will set the tone, the worker or the children? The worker can do much here to affect the entire group mood. For example, noise level can be somewhat controlled by keeping music at low levels. Certain areas within the unit can be designated as quiet areas, while others can be areas for noise, games, and other activities. Activities and programs can be planned to allow transition from noisy competitive activities to slower, more quiet times. For example, snacks, showers, and a brief unit cleanup can be scheduled between a football game and bedtime.

One area in which the child care worker must directly control mood is in dealing with a "contagious" child. Dr. Fritz Redl talks about the effect of contagion on the group. He explains contagion as a psychic communication by a child who is acting out the wishes of other children.[6] For example, a boy who has just made a phone call home may return to the living unit and start making comments about another child's mother. Then other children pick up on it and soon there is arguing about almost everything as the contagion escalates. Here the child care worker could remove the contagious child and spend time alone with him, change the atmosphere by lowering lights, suggest a structured activity, or discuss with the child his feelings about home;

but to let the contagious child go undirected would be asking for a larger, more uncontrollable group problem.

Group Norms and Value Systems

The worker must be aware of how the norms of the children's group differ from his or her own. Often in a group of children, spoken values and norms and private behavior do not coincide. For example, a child who has high status may voice the feeling that it is not cool to talk to adults about real feelings, yet in a one-to-one situation with a worker this same child may pour out everything. Followers and isolates in this case would go by the spoken norm of "clamming up," feeling that this behavior is a means of gaining acceptance by those at the top of the ladder. Suggestions from group leaders meet the impulsive needs of these children and they react. Here, the child care role is to make the group aware of discrepancies between stated norms and private behavior. In essence, this is really helping the group to look at its defenses. The group treatment goal in the above example would be to change the group norm to one of openness.

There are many other behaviors based on expectations and norms that are common to groups of children in placement and are really used as defenses. Some examples are bragging about sexual conquests, denying feelings of separation and loss and any negative feelings about families, and denying the importance of careers or school. In any of these cases, the worker can work with group leaders to get them to open up and be more honest about private feelings. If group leaders publicly sanction a behavior, then others in the group will tend to follow suit.

Even fighting has its own set of rules, evidenced by the familiar statement "he swung first." Impulsive children cannot follow the group expectations and will fight at the drop of a hat, thus finding themselves in violation of an adult norm about fighting and the group norm about the right to defend yourself.

Any new child care worker must make it one of his or her immediate tasks to discover the group norms and jargon. All workers, however, must remind themselves to compare their group's behavior with that of normal groups of the same developmental level, not with some idealized model that exists only in the minds of institutional staff.

Provider of Relationships

The element most basic to relationship building is trust, a characteristic that children in placement possess in small amounts. The worker must begin relationships with the building of trust. This can only be done through consistency and follow-through. For example, if the worker promises to get a child an Afro comb tomorrow, getting the comb next week is not consistent. A worker should try never to offer things he or she cannot follow through on. If the worker sets a time to talk over a problem "later tonight," he or she should make every effort to do that; otherwise he or she should say, "I'll talk to you about it, but I can't promise just when; please remind me again." This is the more honest approach, for all child care workers know that it is dangerous to promise that they will have a certain amount of free time at any specific time during the day. It is also more honest and trustworthy for a worker to admit to a child that he or she cannot help the child with certain problems and that another worker might be better equipped to do so.

The above are all examples of the process that any child care worker must go through to prove to an untrusting child that this is one adult who is genuine, who really cares, who listens and follows through. This process is the basis of trust.

Another important thing to remember in relationship building within a group is that each child is an individual with unique needs. Any attempt by a worker to build a relationship must begin with an awareness of the particular child's needs. For instance, the leader-type child knows the group and usually has quite a bit of courage. The worker must show that he respects and admires these strengths by helping this child to be a team captain or a group representative on an agency council or by trying to help the child get jobs within the agency or community that require some leadership ability. The worker must also be open in dealing with whether a child's leadership qualities are being used positively or negatively.

The isolate-type child is often the stranger or the "new kid." It should be a general practice to prepare the group in advance for the coming of any new child by telling them something about the new group member. With the isolate, the worker must become a bridge from the child to the group.

The scapegoat child on the other hand has different needs. This is the child who misunderstands the group norms because he is so preoccupied with himself. To build relationship in this case, the worker must show the child how he provokes the group. Then the worker should try to find areas in which this child can succeed outside the group until there is sufficient time to help the group understand his needs.

One underlying element in the building of trust within a whole group is the quality of supervision. Often workers fall into the habit of a surveillance type of supervision. For example, if children are not allowed to go to the bathroom alone, or can never have another child in their rooms, or if office doors and other doors within the unit are constantly locked, the tone of distrust has already been established by the workers and the agency. In essence, the worker is saying, "You must be watched constantly, you cannot be trusted out of my sight." The good child care worker will know which children can be trusted alone and when. He or she will know which activities need supervision and which don't. It is absolutely crucial that an overall tone of trustful supervision be established in order for individual trusting relationships to develop.

Provider of Safety

This child care role involves four tasks: reduction of threat, reassurance, reduction of ambiguities, and controls on competition.[7]

Reduction of Threat

To reduce threat, the worker must be able to control both verbal and physical negative aggression within the group. He or she must also be able to deal comfortably with the child who is at the top of the power structure. In other words, the worker must use his or her authority comfortably. We often feel guilt about authority and tend to equate it with punitiveness. Two mistakes are often made concerning use of authority in child care. The inexperienced worker may not have worked through his or her own feelings about "the establishment" and will thus find himself or herself in a role conflict. The experienced worker, on the other hand, often regards the established authority role as so final that a child's attack on that role is seen as a personal challenge to his or her competence.

The most serious handicap for the worker in reducing threat is his or her own fear, either of the child or reactions to the child. Supervisors must urge their workers to admit to these fears so that other workers will be able to provide support when necessary. Fear of children by the working adults can contribute to contagion and intimidation within the group. A worker must always remember that the overwhelming appearance of a 200-pound, six-foot adolescent boy can often conceal the hurting, needing little boy inside, who does not like himself when he is angry any more than the worker likes him.

Reassurance

Reassurance involves letting the child know that you, the worker, are personally concerned about his or her physical and emotional needs. The worker can show this concern in several ways: personally taking the child to the nurse for treatment, setting aside a time each night at bedtime to spend five minutes alone with each child to see whether he or she needs anything (clothing, phone calls home, birthday cards to send to family, etc.), and providing for privacy needs (allowing individual showers at different times of the day, etc.). Reassurance also involves giving support verbally and physically when a child has had either a positive or a negative experience.

Reduction of Ambiguities

There are several built-in vehicles in child care that enable the worker to fulfill this important role: structure (rules and regulations), routines (certain times for waking up, cleaning up, meals, and bedtime), and activity programming. Definite behavioral expectations must be made clear to all children, and each child must have a written treatment plan that gives him or her direction and a means of evaluating daily and weekly progress toward certain goals.

Children must be made aware of the limits and consequences of unacceptable behavior. Above all, staff members must work as a team, enforcing the same behavioral expectations and consequences. For example, if children are expected to make their beds during a specific time, all workers must see that the task is completed whether or not they tell the child to do it, ask the child to do it, or just set the general expectations of neatness.

Controls on Competition

This task again involves an awareness of group leadership. The child care worker must know which children are strongest physically and in personality. Skill is needed in this area in regulating group activities so that children at various developmental levels have equal opportunities to participate in a group experience.[8] The worker must provide activities that will allow each child to excel in some way in order to build confidence and ego strength.

Provider of Corrective Experiences and Hope

Providing corrective experiences is what child care is all about. There are many vehicles for doing this within a group: relationship building, group meetings, therapy sessions, setting expectations, and various child care techniques such as the life-space interview, teaching alternative behaviors, and careful programming. These techniques are dealt with in depth in many other articles and modules and will not be discussed here.[9]

Provision of hope is one final function necessary to therapeutic group work that must be mentioned. If any child who is angry or depressed, anxious, and distrustful is to progress and make changes, he or she must feel some sense of hope that things can be better. For a child who has a very grim looking future in his or her natural family or no family resources, the instilling of hope can be one of the child care worker's most difficult tasks. There are things that the worker can do. First, short-term goals (e.g., make your bed properly for a week) must be used as steps toward more long-term ones (e.g., general cleanliness and pride in surroundings).

Secondly, the worker must support group achievements. Even if the team came in second, they were close to winning and deserve a celebration. This is one way of instilling group pride. Individual achievements and progress within the group must be recognized. For example, when a small, underdeveloped boy finally reaches puberty, there's nothing wrong with a celebration, or if that seems too uncomfortable for the worker, he or she can urge the boy to spend time looking at himself in the mirror every day and pointing out to himself the beauty of his body (one way of achieving an important adolescent developmental task). All of these things instill pride and hope in one's future.

Finding activities in which each child can achieve something is another way of giving birth to hope. If there is a weekly group incentive program of some sort and a child who has done the best in the unit or in school is rewarded, how about also giving a reward for the child who has improved the most?

Finally, there is one child care function that underlies all the others. A child care worker is much more than a traffic cop or playground supervisor who stops little children from running off cliffs. The worker has the unique opportunity to provide children in placement with something they very often have not had. The worker has the opportunity to make children feel cherished. To be cherished in this sense means to be loved just because you exist, with no strings attached. There are many things that the worker can do to transmit this message, such as creating goals that are based on the child's individual potential rather than on comparisons to others who are bigger, smaller, or brighter; spending time with a child when he or she has done nothing either specifically wrong or right; touching or hugging the child; and talking to the child about who he or she is rather than what he or she does.

Most conversations between a worker and a child focus on certain parts of the child's life - his or her family, friends, behavior, and so on. The child care worker must make a special effort to consolidate these parts, for the art of cherishing is based on viewing the child as a unique entity to be accepted as a whole.

References (see p. 276 for full listings)

1. J.D. Salinger, The Catcher in the Rye (New York: Random House, 1951), p. 244.

2. Morris F. Mayer, "The Group in the Residential Treatment of Adolescents," p. 483.

3. Alan F. Klein, The Professional Child Care Worker, p. 95.

4. Ibid., pp. 196-200.

5. *Encyclopedia of Sociology* (Guilford, Conn.: Dushkin, 1974), p. 277.

6. Fritz Redl, *When We Deal with Children*, p. 199.

7. Klein, p. 199.

8. Wayne Ouderkirk, *Programming in Residential Child Care* (Albany, N.Y.: Continuing Education Program, School of Social Welfare, State University of New York at Albany, 1979). See also pp. 296 and 299 of this curriculum.

9. Redl, pp. 35-69; see also pp. 223, 229, and 295 of this curriculum.

SESSION OUTLINE: THERAPEUTIC USE OF THE GROUP

Time: 2½ hours

Space: Room for the large group and for role playing

Equipment: Blackboard and chalk, or easel pad, stand, markers

Handouts:
"Self-Assessment: Building Therapeutic Groups," p. 280
"Child Care Worker's Role in Building Therapeutic Groups," p. 281
Role Plays 1, 2, and 3, pp. 282-87
"Building Therapeutic Groups: Tasks, Tools, and Techniques," p. 288

1. Introduction 5-15 minutes

The trainer distributes the "Self-Assessment: Building Therapeutic Groups" handout and asks participants to respond to the statements by filling in the "before training" boxes. The trainer explains the importance of participants' repeating their self-assessments at three months and six months after training. After doing the last assessment, participants are to return the completed form with their comments to the trainer.

The trainer explains the difference between a "crowd" and a therapeutic living group, defines the group as a therapeutic tool, and lists some reasons why therapeutic groups are not easy to form within residential settings for children (see p. 263 of resource paper). At this point the trainer may wish to ask the group for additional reasons. The trainer then states that there are five basic child care roles necessary for building therapeutic living groups. As he does this, he hands out the outline "Child Care Role in Building Therapeutic Groups."

2. Role Plays

a. Preparatory Note

Role playing can be threatening. Depending on the mood or comfort level of the group you may need to do a warm-up exercise. For example: Divide group into pairs or threes and have members brainstorm about ways to use role playing with children or in training. Make sure you build safety into role plays by explaining that the incidents are scripted and that players are not necessarily playing a therapeutic and totally effective worker. If such a warm-up is used, the time frames for the rest of the session need to be adjusted accordingly.

b. Introduction 10 minutes

Using role plays 1 and 2, the trainer asks for volunteers to play each role. The players are given copies of the role plays and have five to ten minutes to go off to a corner of the room to prepare their role play. While the players are preparing, the trainer can distribute the role plays to the rest of the group to read.

When players are ready, the whole group is instructed to jot down at least two observations, questions, or comments about the role plays as they are played out.

c. Role Play No. 1 25 minutes

Introduce the first role play as a situation that involves the awareness of the staff team as a group. Point out that observers should gear their comments to that issue. The trainer may cut the role play at any place once he feels that important points have been made. The trainer should tell players in advance that he may cut in. After the role play, the trainer should ask the group for their questions and observations. If there is little response, or participants seem to be off on a tangent, the trainer may refer to the discussion questions included with the role play.

d. Role Play No. 2 25 minutes

Follow same procedure as for role play no. 1. Introduce this situation as one that involves the child care worker as observer/communicator. Refer to discussion questions for this role play.

As an alternative to the given session, the trainer may ask the group to come up with situations to role play that are more pertinent to their immediate work situation. Be sure that their situations are examples of the first two child care roles listed in the outline: builder of awareness of team as a group and observer/communicator. Role play no. 3 is included with discussion questions as an example of the child care worker as provider of safety. For the observer/communicator role, the trainer could use a videotape or film of a typical group of children involved in some routine or activity and ask participants to record as many observations as possible about group structure, status, role, subgrouping, mood, norms, values, and so on. Also for the observer/communicator role, the trainer could suggest that each participant bring a sociogram of his or her group of children in which each child has written the name of the child he likes most in the group. The worker then makes a chart with circles representing each child and lines with arrows between circles, designating who likes whom.

e. Summary 10 minutes

At the end of this section, the trainer should ask if there are any remaining techniques, tools, or suggestions that relate to performing either of these first two role plays. The trainer may wish to add suggestions (see resource paper, pp. 264-67).

BREAK 15 minutes

3. Small Group Tasks 20 minutes

At this point, the group should be randomly divided, by counting off, into three groups and assigned the following task: Each group is given one of the last three child care roles on the outline - provider of safety, provider of relationships, provider of corrective experiences and hope. The group's task is to brainstorm for 15 to 20 minutes and accumulate as many ideas as possible as to what specific techniques, tasks, situations, or tools child care workers can use in their daily routine to fulfill the respective role functions.

Let participants know that they will be reporting back to the large group. The trainer may wish to give them a piece of flip chart paper and marker for reporting purposes.

4. Processing Small Groups 30 minutes

Trainer should ask each group to report its findings, then ask the large group for any additions.

5. Summary 5 minutes

Trainer summarizes by again stating the necessity of all of the five basic child care roles in the building of a therapeutic living situation.

Trainer distributes the handout entitled "Building Therapeutic Groups: Tasks, Tools, and Techniques."

ANNOTATED BIBLIOGRAPHY

Klein, Alan F. "The Living Unit." In *The Professional Child Care Worker*. New York: Association Press, 1975, pp. 94-108.

In this chapter Dr. Klein emphasizes the important role of the child care worker in establishing a therapeutic living group. He points out several reasons why therapeutic groups do not "just happen." He lists and describes the following tasks of the child care worker in establishing positive group experiences for children in residential care: understanding group properties and processes, establishing tone or climate within a group, understanding the status of each child within the group (i.e., follower, leader, etc.). He discusses the positives of permitting children to make group decisions and the idea of group goals. This chapter is a very basic look at the child care role in groups and does not elaborate on techniques and tools available to the worker to perform the described roles.

Mayer, Morris F. "The Group in the Residential Treatment of Adolescents." *Child Welfare* 51, no. 8 (October 1972).

In this article Mayer discusses five concepts involved in changing a group of children from a crowd into a therapeutic group. These concepts include communicating concern for therapy from administration to residents, using authority constructively, providing balances to authoritarianism, being aware of tasks necessary to group formation, and bringing group rituals into consciousness.

Redl, Fritz. *When We Deal with Children*. Chapters 1, 2, and 5 of Part 3, *"What About Groups?"* New York: The Free Press, 1966.

Three chapters in this classic by Redl are specifically helpful in understanding group dynamics and what to do with them.

"Group Emotion and Leadership" (pages 155-196):

In this chapter Redl describes ten types of groups that each form around a central person. He discusses in depth the types of children, age range, etc., who are likely to be involved in each of the types of groups and why these groups form. Understanding these group types could be a helpful assessment tool for a child care worker to use in discovering the needs of each child and subgroup in his/her care.

"The Phenomena of Contagion and Shock Effect" (pages 197-213):

Here Redl describes, analyzes, and discusses practical applications of the effects of group codes, culture, norms, personalities, size, structure, program, etc., on a phenomenon he labels contagion (the spread of behavior from one person to another).

"The Art of Group Composition" (pages 236-253):

Here Redl discusses which type of child will fit best in specific types of groups. He emphasizes the importance of matching children's needs with group placements most geared to meeting those needs. In the later part of the chapter he also discusses what to do when a child and group are mismatched.

All three of these chapters are musts for any treatment-oriented child care group worker, but the reader must remember Dr. Redl's love of his own jargon.

HANDOUTS

SELF-ASSESSMENT: BUILDING THERAPEUTIC GROUPS

How much will you get out of this training session? This form can help you to find out; it can also help the trainer to evaluate and improve future training. Respond as accurately as you can.

In the appropriate boxes below, answer items (a) and (b) with a simple "yes" or "no"; answer (c) through (f) by using the number on the scale that most closely represents your level of activity for each item. Repeat this process at three and six months after training.

a. I can identify the five child care worker functions necessary to developing a therapeutic living group.

b. For each function, I can describe at least one task I perform or tool I use as a means of fulfilling that function.

c. I make it a point to assess the group mood and tone and to communicate my assessment to my fellow workers.

d. I try to keep clear the group structure in my unit - where each child fits into it, its values, etc.

e. I use techniques specifically geared to develop the children in my unit into a cohesive group. In other words, I try to carry out the five child care worker role functions with the group.

f. I make efforts to establish and maintain a professional group consisting of myself and other members of my working team.

1	2	3	4	5	6	7	8	9	10
never		occasionally		sometimes			often		always

	a. Functions	b. Tasks	c. Mood	d. Structure	e. Techniques	f. Staff Group
1. Before training						
2. Three months after training						
3. Six months after training						

If training is effective, your knowledge and activity should increase. Please share your personal results with your trainer.

CHILD CARE WORKER'S ROLE IN BUILDING THERAPEUTIC GROUPS

An Outline

I. What makes a group therapeutic?

II. Child care worker's role in developing therapeutic group

  A. Builder of awareness of staff team as a group
    1. Communication (verbal and written)
    2. Dealing with conflicts
      a. personality; working styles
      b. role; other professions
      c. agency policy

  B. Observer/Communicator
    1. Group structure
      a. status
      b. role
      c. subgroupings
      d. developmental levels of children
    2. Group mood or tone
      a. who establishes this, you or the children?
      b. "contagion"
    3. Group norms and value systems - awareness of differences

  C. Provider of Safety
    1. Reducing threats
    2. Reassurance
    3. Reducing ambiguities

  D. Provider of Relationships
    1. Trust
    2. Individualization according to child's needs (leader, follower, isolate)

  E. Provider of Corrective Experiences and Hope
    1. Programming for success
    2. Teaching alternative behaviors through life-space interviewing, etc.

ROLE PLAY NO. 1: STAFF TEAM AS A GROUP

Child Care Workers:

Bob (Bonnie):	10 years of experience, no formal education
Jeff (Jane):	new worker, in the unit for only 2 months, with no previous experience or related training
Karen (Ken):	1 year's experience, 2 year degree in child care
Pete (Penny):	1 year's experience and 4 year degree in unrelated field

Supervisor:

Al (Alice):	5 years in this unit

Scene: Team Meeting

Karen and Pete have had a bad shift because of the continuous acting out by John (age 15). This has been going on for weeks and this week they had to physically restrain him several times.

Bob doesn't want John removed and says he has no problems with the boy on his shift. Jeff agrees with Bob (as he usually does).

Al states that they should decide how to work with the boy and that Bob obviously feels he has some effective methods.

Karen and Pete continue to insist that John does not belong in this unit. Al says they haven't given the boy enough of a chance.

Discussion Questions:

1. What is the real conflict here?
2. Is the staffing pattern set up to best utilize strengths and weaknesses?
3. What is the relationship between Al and Bob?

4. Can log entries or other written communications be directed to help resolve this conflict?

5. How could Bob's experience and Karen's theoretical knowledge be used constructively rather than in a way that causes conflict and inconsistency?

6. Does the conflict presented call for outside, neutral help? Why? If not, how can it be resolved?

ROLE PLAY NO. 2: CHILD CARE WORKER AS OBSERVER/COMMUNICATOR

Child Care Workers:

Dennis (Denise)

Rob (Roberta)

Children:

Tim:	11 year old who has been in cottage 10 months
Eric:	10 year old who is big for his age and Tim's best friend
Eddie:	10 year old boy who is withdrawn, shy, and new to the unit

5 other boys

Scene:

The group has just returned to the cottage after losing the championship volleyball game. The child care workers direct the boys to take showers and get ready for evening snacks and free time. Upon returning to his room from the shower, Tim discovers that some candy bars that his mother had given him are missing. He runs to the office and tells the two workers that the candy is missing and that they better do something about it because he's sick of having all of his stuff stolen.

Rob and Dennis (Roberta, Denise) immediately call a group meeting and state that until they find out who is doing the stealing, everyone will be restricted from all activities and no one will be allowed to go into anyone else's room. Everyone leaves the meeting loudly protesting the unfairness of the restriction.

Eddie comes into the office after the meeting and says that he stole the candy. When asked to bring it to the office, he says that he already ate it. Hearing a lot of noise and complaining in the hall, Rob and Dennis (Roberta, Denise) go out to find that Eric and Tim are searching rooms to find the candy.

Discussion Questions:

1. What is the mood or tone of the group at the beginning of the scene?
2. How will that mood be affected by the actions of the workers?
3. What might have been done differently by the workers based on the mood of the group?
4. What can you say about Eddie's status in this group? Did he really steal? If not, why is he saying so?
5. What can you say about the status of Eric and Tim within this group?
6. Can you speculate about any group norm concerning personal property and stealing?

ROLE PLAY NO. 3: CHILD CARE WORKER AS PROVIDER OF SAFETY

Child Care Workers:

Jim (Joan): Experienced child care worker

Tom (Terri): Experienced child care worker

Rich (Renee): New child care worker, has worked only 3 weeks

Children:

Bob: Boy aged 14

Kevin: Boy aged 15

Joe: Boy aged 13

4 other boys

Scene:

In the cottage (a unit of fifteen boys), a few have gone from school directly to activities outside the cottage; the rest have returned to the cottage where staff shift change is taking place.

Jim is going off duty and tells Tom and Rich that Bob and Kevin were pulled out of school early because of a fight. He has talked to both and has restricted them to their rooms for the evening and everything is fine now.

Joe has just returned from making a phone call home to his mother. When he returns he immediately asks Rich to play cards with him, and Rich does.

Tom takes five boys and goes down to the gym to play basketball.

As soon as Tom leaves, Bob and Kevin start egging each other on by making remarks from their rooms, which happen to be across the hall from each other. Rich leaves Joe to tell them to knock it off. They reply it's none of his business. He tells them to come into the office. They go - muttering obscenities. He slams the office door behind. Joe and the other boys rush to the hallway outside the office commenting that if Tom was here, this wouldn't be happening.

Discussion Questions:

1. How much ambiguity is there in the situation between Bob and Kevin as it is left when Jim goes off duty? Do Tom and Rich really know what happened, what group mood is, etc.?
2. What can you observe about staff coverage during this incident?
3. What are Joe's needs? How do they conflict with those of Bob and Kevin?
4. What are Rich's needs? How must he be feeling?
5. Is there a feeling of safety in this group?
6. Does Rich feel safe?
7. What should Tom be doing?
8. Were the consequences for Bob and Kevin appropriate? Why or why not? Do they know where they stand?

BUILDING THERAPEUTIC GROUPS:
TASKS, TOOLS, AND TECHNIQUES

A. Building Awareness of Staff Team as a Group

1. Expressing disagreements in team meetings rather than in front of children.

2. Communicating verbally and in log entries exactly what is going on with each child, the mood of the group, etc., to co-workers.

3. Following through on restrictions set up by co-workers.

4. Following through on treatment goals for each child as established by a treatment team.

5. Asking to meet with workers from other departments to iron out misunderstandings, coordinate efforts, communicate information and staff feelings.

6. Volunteering to work for each other in times of personal crisis.

B. Observing/Communicating

1. Describing status of each group member (constructing a sociogram); i.e., who are leaders, followers, isolates, etc.?

2. Listing the norms of the group and looking at which are different from your own?

3. Using leaders to be team captains, committee heads, representatives, etc.

4. Listing as many incidents or situations as possible that affect group mood or tone and describing what the effect of each usually is (e.g., competitive sports, home visits, therapy sessions, phone calls home).

5. Controlling lighting, noise level, and other factors that affect group mood (i.e., make plans for noisy times and quiet times, noisy areas and quiet areas); programming for transition from noisy to quiet activities.

6. Isolating a "contagious" child when appropriate.

C. Providing Relationships

1. Building trust (following through on promises).
2. Making time to spend with each child.
3. Being honest in talking to the child about feelings (both yours and his).
4. Helping child label own feelings.
5. Developing treatment goals that fit each child's performance and developmental level.
6. Relating to each child's strengths as well as weaknesses.
7. Analyzing quality of your own supervision, e.g., do you constantly watch all children all of the time or do you know when not to watch?

D. Providing Safety

1. Controlling verbal and physical aggression.
2. Learning to deal comfortably with child who is at top of power structure.
3. Analyzing your own comfort in using authority.
4. Talking to co-workers, supervisor, etc., about fears of dealing with certain types of children - asking for help!
5. Reassuring children that you are concerned about their personal needs (physical and emotional), e.g., personally escorting a child to the nurse, setting aside time each day to see if each child needs anything.
6. Making conscious efforts to provide privacy for each child, e.g., providing for private showers, areas where each child can be alone.
7. Using physical reassurance - hugs, touches, etc.
8. Carefully planning routines (bedtime, wake-ups, meals) and activities (games, trips, etc.).
9. Clearly spelling out behavioral expectations for children as soon as possible; clearly spelling out consequences for unacceptable behaviors.

10. Using competition carefully; placing some controls on it within the group.

E. Providing Corrective Experiences and Hope

1. Building relationships.

2. Setting up group sessions to deal with certain developmental or behavioral problems.

3. Setting up individual therapy sessions.

4. Learning how to do effective life-space interviewing.

5. Planning routines and activities that will help improve skills and will meet needs of all in the group.

6. Constructing treatment plans that have short-term, intermediate, and long-term goals.

7. Looking for ways to instill and reinforce group pride (i.e., even if the team comes in second, there may be cause for a celebration).

Activity Programming

by Wayne Ouderkirk

290

INTRODUCTION

The residential care system contains many variables: the group composition, the agency setting and viewpoint, the school, the food, the staff, the opportunities for interaction, and other factors. As a result, much that happens in any child care setting is unpredictable. This unpredictability is limited somewhat by two significant child care techniques or tools: cottage routines (e.g., at bedtime) and free time activity programming. Here we will cover activity programs only.*

If the reduction of unpredictability were the only important feature of programming, there would be no need for this module. Few, if any, child caring settings omit routines and free time activities. But there is much more to these tools than their power to manage time and events for child care workers. It has long been recognized in the literature of professional child care that activities have what Redl calls a therapeutic function.

Since new workers continually enter the field of child care, and since child care has been long under the thumbs of other professions, this therapeutic function - as well as other significant child care tools - has been either neglected or else interpreted to child care workers as a holding pattern or conduit for others' therapy. The child care role and contribution have been missing. This module is an attempt to put it back.

In any professional training program for child care workers, the unique therapeutic role they play in the care of children must be the primary focus - stage front, center. The following statement is typical of the view presented in the literature of child care:

> [We] are convinced that a "supportive" use of programming, to further the success the individual therapist can have with his client in his interview room, is not enough. For the type of children we are talking about in these studies, we boldly claim that the function of programming must move directly into the core of the treatment process itself.**

The message is clear and definite; do not mistake it for a scientific approach to the mere management of children. This portion of the child care worker's role - and by implication much else besides - is therapy, in its own right.

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* For a training session on cottage routines, see Wayne Ouderkirk, Programming in Residential Child Care, Continuing Education Program, School of Social Welfare, State University of New York at Albany, 1979.

**Fritz Redl and David Wineman, The Aggressive Child, pp. 328-29.

That claim is the underlying assumption and starting point for this module. Therapy, to be therapy, must be done by professionals. This module attempts to provide a professional training experience for child care workers who must use these therapeutic techniques to help children in care.

Two other points: first, child care is unique, different from other professions that find themselves joining forces in the context of residential care. It is not social work, not psychology, not teaching; it is child care. Therefore, a professional training experience for child care workers won't necessarily look like a social work or psychology or education training experience.

Second, because it is or can be a professional activity, child care needs to resemble other professions in some ways. This module will be different in some ways, but it will also share professional standards. It will demand thought and work and commitment from participants.

BEHAVIORAL OBJECTIVES

After participating in this session, child care workers will be able to

1. Identify four needs of children in placement that can be met by purposeful play.
2. Analyze any activity using three activity dimensions.
3. Design a play program for a child in care, based on a case description.

BEHAVIORAL CHANGES

1. Child care workers will use activities consciously as part of their treatment activities.
2. They will discuss such use in team meetings.
3. They will include activities as part of their written treatment plans. This use will be correlated with their child care goals; the activities will be part of the techniques used to achieve the goals.

RESOURCE PAPER: ACTIVITY PLANNING

Child care workers are well aware of the need children have for structure. Perhaps the most universal advice given new child care workers is that they must be able to provide the children with consistent limits. But structure has many meanings, consistent limits being only one of these. As used here, structure simply means repeated patterns in the child's life-space, patterns that are consciously created and used by those who control the environment. For various reasons (most often the reasons for placement), the need of children in residential care for structure is pervasive and is seen in most, if not all, aspects of their lives.

It may seem paradoxical to say that play is one such aspect. Play seems to connote the absence of structure, a free, unfettered activity in which children can immerse themselves and forget their problems. However, that description would be more suitable for adult recreation than for most forms of children's play. To be sure, children can and do lose themselves in play. But play has other, more significant functions.

For all children, play is an important developmental stimulus. They use it to master life skills related to sex roles, dealing with the environment, and independence from parents. By deliberately acting out parental roles, imitating adult tasks and actions, or seeking safety in a group of peers, children use play to accomplish developmental tasks and to work out associated conflicts.

Disturbed children also play. However, these children have been harmed in one way or another by their experiences; often the adult roles they have seen have been less than perfect. The result is an inability to use play to resolve conflicts, to emulate adaptive and adult behavior, or to enhance self-esteem. So in many instances, child care workers have to teach their charges either how to play, or how to make better use of play.

With the exception of instructions for a given game or activity, the teaching takes the form of providing opportunities for the children to experience their own capacities and those of the world. But it is essential that this teaching be deliberately planned to work toward the goals the worker and the treatment team have devised and that it step out of the world of recreation and into the realm of therapeutic tools.

This last point must be emphasized. If we are to provide a therapeutic milieu, then every aspect must be evaluated and designed to help children outgrow the need for residential care. To be sure, some aspects, such as the maintenance schedule for the buildings, are not therapeutic tools. Rather, they are supportive. The crucial point is that such items should not interfere in any way with therapeutic intervention. But activities that can provide the children with specific tasks and issues relevant to their treatment are indeed therapeutic tools in themselves and are not mere time fillers and distractions. This will become much more evident after we examine how the skillful use of activities can help a child and what the characteristics of such activities are.

There are actually numberless ways in which activities can help children grow. Besides those mentioned above in describing the functions of play for all children, there are several general areas that need to be singled out in child care.[1] Perhaps the most pressing need of acting-out children in residential treatment is social skills.[2] Most of them have come into placement with a past history of "poor peer relations," characterized by fighting, teasing, and lack of cooperation with other children, to say nothing of their interactions with adults! This problem is exacerbated by the child care setting, a social system that pervades the child's life. Withdrawn children present an analogous problem: they don't play well with other children because they don't play at all.

The worker is faced with the twofold task of getting these children to interact in positive ways and involving each child in ways that will develop the social skills needed by that child. A primary tool here is the skillful use of activities. By the manipulation and variation of activities presenting different social challenges, the worker can provide both types of children with positive social experiences. Clearly, for normal children, play is a strong socializing factor. But disturbed children have not experienced positive socialization and so cannot make use of this factor without the planned intervention of the child care worker.

Underlying the poor social skills so evident in children in care is another problem they all seem to share: poor self-esteem.[3] How many times have child care workers read the records of a child and found that phrase repeated over and over? How many times have child care workers written that phrase in their own reports and recommendations? The nonrhetorical question is, How can we help these children improve their self-image?

If we look back at their previous experiences, we will readily find an answer. They come to us dragging a heavy burden of failure; they are almost all understandably behind in their school level, have been in all kinds of trouble, are unable to get along socially, and - failure of failures - they have wound up being placed in a strange place, away from their family and what little security they have known. These children need success. Child care workers - it is almost a professional cliché - must program for success.

The program for these children must start with things they can do well. In some cases, the beginning will be very elementary, in others very advanced. The crucial factor will be the possibility of success. It makes little sense - indeed, it is antithetical to treatment - to expose a child to situations in which he or she will fail. Enjoyable, successful experiences must be made available by the child care worker. As a child builds up a repertoire of enjoyable activities and a history of successes, that child begins to perceive himself or herself as good, as capable, as one who does things well. Self-esteem can be attained, but the child care worker must provide the means.

One of the most gratifying returns derived from play is the freedom it affords us to express ourselves.[4] Bodily movement, the release of tension, and the use of control and power are all parts of play that attract us to it. Most of us can readily see how this aspect of play can benefit disturbed children. Very frequently, they don't even know how they feel. Through activities - supplemented by other child care functions - workers can help children recognize their feelings. A crucial addition here is provision for expressing the tension that emotions can produce; this tool most child care workers already utilize. Children without confidence in their bodies can be helped to learn about them through activities. Children with such confidence can be helped to experience their bodies happily and successfully. So this expressive aspect of play allows for emotional and bodily expression, both of which are needed by most children in care.

In addition, activities can be used to teach many things.[5] Self-control, limits, and rules are all part and parcel of activities, as we shall see. So the activities become a teaching medium through which children acquire significant life skills. Also, the worker can exploit activities to help children to discover, to expand, to participate in their world to the extent that they are able. The huge range of activities in arts and crafts can be used to teach not only the skills required, but also the characteristics of materials, aspects of different cultures, and the possibility of creativity (an expressive function). Such a dynamic use of programs can present the child with opportunities for insight into himself and the world around him.

Many possible therapeutic uses of activity programs are not specified in this account. Indeed, it would be impossible to specify every such use. Whatever general schema is used to classify the various uses, this much must stand out: the several functions are closely related and actually overlap (e.g., expressing anger in socially acceptable ways is a skill combining two of the categories given here). This fact points to the importance of planned, conscious use of activities. Their characteristics can help us help children, but only if we manipulate the program.

To that end, we must devise strategies for using the program. Although a strategy will vary in accordance with the permanency plan for each child, there are some general things we can say about designing an activity program for that child. Redl and Wineman have described in detail fourteen therapeutic functions of activity programming.[6] At the risk of oversimplifying that account, I would like to summarize those functions in two complementary processes: minimizing and maximizing.

First of all, care must be taken to *minimize* situations which typically provoke a child into his or her symptomatic or negative behavior. Obviously, this involves knowing the child well. To program preventively provides the child with opportunities to experience situations in which he or she can succeed, have positive experiences, and begin building self-esteem. The worker must begin with things the child is capable of doing with a minimum of challenge. Although this may sound simple, the task is frequently complicated by the array of skills a child, especially a teenager, may possess. To minimize conflicts in a program for such a youth, the worker must take care not to plan below the child's existing skill level, while still bearing in mind that the skills are affected by the child's emotional limitations. A delicate balance indeed!

Complementary to the preventive function is the growth producing aspect of programming. While we are preventing conflicts and building confidence and esteem in a child, we are simultaneously *maximizing* growth. After consolidating the strengths at the child's initial level, the worker can systematically challenge the child by gradually raising the level of difficulty of the program relative to that child's needs. This maximization of growth also requires a thorough knowledge of the child, since challenging him or her at a level above present capacity must be done carefully and thoughtfully, lest the experience yield failure, consequent frustration, and loss of ground.

These two strategies, "minimizing conflict" and "maximizing growth," are the core of therapeutic programming. An activity program designed with them in mind is a therapeutic tool, since through it a child can gain insight into difficulties, gain mastery of techniques that constructively diminish problem behaviors, build up a cache of positive experiences and self-esteem - and have fun! A word of caution, though. We are singling out one component of child care in a residential setting. In practice, however, it is interwoven with other strengths of the milieu. Thus, it should not be seen as the end-all of treatment, but as another opportunity for children in care.

In order to utilize activities in accordance with these two strategies and to answer the children's needs described earlier, workers need a framework in which to categorize activities as "good for purpose x, bad for purpose y." Such a framework will lay out the major facets of activities that influence the behavior and reactions of those participating. This categorization is achieved through activity analysis, a phrase which "refers to the breaking down of an activity to see what its components are and how they can be matched to treatment goals."[7]

There are several ways in which activities can be analyzed.[8] Here we will use the three dimensions singled out by Karen VanderVen in her description of therapeutic programming.[9] She points out three activity dimensions relevant for programming for disturbed children: body motions, amount of competition and interaction, and degree of structure. Each of these are found to varying degrees in any activity. And the degree of each factor is the essential point for child care workers. What follows is a brief explanation of each dimension, how it relates to one or both programming strategies, and how it can help children achieve the treatment goals or needs described earlier.

The body motions of an activity are simply what actions one has to perform in order to participate in that activity. Some games and crafts require small-motor and/or eye-hand coordination; others require large-motor movement. Some are slow, some fast, some can be done while sitting, others are much more active. That much is obvious. One can minimize conflicts for a child with poor eye-hand coordination by choosing a crafts activity that is not too detailed and structured. A young child may be able to hammer nails into wood (both hands on the hammer, please!); an older child with the same problem might prefer to do hammered metal work. On a more active level, the younger uncoordinated child may do well at circle games; the teenager may be better in relay races than in a basketball game. In these examples, conflicts are being minimized and growth maximized by providing activities chosen for the appropriate amount and type of physical movement. By using the strategies of minimizing problems and maximizing growth in planning sets of such activities, the child care worker helps the child build a range of positive experiences and gain in self-esteem and in some social skills.

Social skills are the important consideration for the second dimension: amount of competition and interaction. For the teenager who becomes hostile and aggressive in competitive situations, a highly competitive sports situation is not a good idea, even if he or she has the requisite physical skills. Without a chance to work out the conflicts about competition, such a child will simply persist in a negative pattern of failures in such cases, with strong implications for other social situations. Better to minimize the competition by channeling the youth into less loaded sports like relays in track or swimming, or playing with a worker as a teammate. For a younger child who cannot function on a team, tag might be a good game. A group project that can emphasize individual contributions is a possibility for all (e.g., a collage-mural for the rec room). Withdrawn children can be coaxed into interaction through such activities or through paired-off games, rather than being forced into group interaction. Manipulating this dimension helps minimize conflicts, stimulates social growth, and teaches important life skills.

Degree of structure is the final dimension we will discuss. This is the degree to which the activity and materials control the actions of those involved. On an active level, children of any age with poor impulse control would have difficulty playing a highly structured game. A fifteen-year-old with a short attention span and abundant energy cannot function for long as a right fielder in a softball game. Again, relays of various kinds might be a better substitute at first. On the other hand, some children might want only highly structured activities, and thus need to learn to function in less structured situations. As before, the worker's attention to this activity dimension helps the children gain a history of enjoyment, growth, and self-expression, while learning valuable things about themselves and their world.

These examples have been brief but, hopefully to the point. In order to learn to program therapeutically, child care workers need to have the conceptual skills outlined here, and they need to practice their applications in both simulated and real situations. The more skillful they become, the better the children in care will be served.

References (see p. 303 for full listings)

1. The following account is based on Karen VanderVen, "Activity Programming," in Foster et al., Child Care Work with Emotionally Disturbed Children, pp. 201-243.
2. Ibid., pp. 213-215.
3. Ibid., pp. 211-213.
4. Ibid., pp. 201-211.
5. Ibid., pp. 208-210.
6. Redl and Wineman, pp. 327-94. The account these authors give, though dated in some ways, remains unsurpassed for its definition of the therapeutic functions of programming.
7. VanderVen, p. 219.
8. For an alternative to the categories used here, see James K. Whittaker, "Program Activities," in Albert Trieschman, Whittaker, and Larry Brendtro, The Other 23 Hours, pp. 100-119.
9. VanderVen, pp. 219-224.

SESSION OUTLINE: ACTIVITY PROGRAMMING

Time:	About 2 hours
Space:	A large room, space for small groups to work
Equipment:	Easel pad, stand, and markers
Handouts:	"Self-Assessment: Activity Programming," p. 306 "Mini-Cases," p. 307 "Case Examples," p. 308

1. Introduction — 5 minutes

The trainer distributes the "Self-Assessment: Activity Programming" handout and asks participants to respond to the statements by filling in the "before training" boxes. The trainer explains the importance of participants' repeating their self-assessment at three months and six months after training. After the last assessment, participants are to return the completed form with their comments to the trainer.

The trainer introduces the topic briefly, emphasizing that the session builds on child care workers' skills and knowledge in working with children.

2. Mini-Case — 10-15 minutes

a. The trainer gives small groups of four to eight the task of analyzing the first of the "Mini-cases" according to the directions given in the handout. Each group brainstorms for five minutes, then reports back. The purpose is to stimulate participants' thinking about programmed activities.

b. As the first group gives its report, the trainer can record it on a flip chart. After that, the other groups can report any additional ideas. The trainer should emphasize responses bearing on the concepts of purposeful play, and rephrase when necessary.

3. Lecture — 15 minutes

Here the trainer presents the important content material that explains, adds to, and summarizes the concepts of play and programming (see resource paper), referring as often as possible to participants' own ideas from number 2 above.

4. Mini-Case — 10-15 minutes

a. This time the trainer rearranges the groups by having participants count off so that there are four or five groups.

They will also work in these groups later, so they needn't move again.

The trainer presents the second mini-case, which is designed to focus attention on aspects of activities that need to be considered in programming. As before, participants are given five minutes to complete the task of analyzing the mini-case.

b. Reports are gathered, as before. This time, the trainer emphasizes responses leading to the dimensions of activities.

BREAK 15 minutes

5. Lecture - Activity Analysis 20 minutes

The trainer presents the concepts of activity analysis, using the dimensions presented in the resource paper or those referred to in reference 8, p. 300 (whichever the trainer feels more comfortable with). Use lots of examples. At the end of the lecture presentation, the trainer can get the group to analyze several activities to reinforce and practice the skill. This practice is important, since the use of the dimensions must be clear before the next experience.

6. Small Group Task 30 minutes

a. The groups are assigned the task of setting up an activity program for a child in care based on the concepts of therapeutic programming and activity analysis. The case examples are used for this exercise. Or the trainer can have each group design an activity program for a child with whom they work. The main point is for participants to use the knowledge and skills presented to match activities to a child's needs and treatment plan.

Alternate Task: 40 minutes

Another possibility is to have the workers (1) make a list of activities they currently use, (2) analyze them, (3) then determine whether their programs match the children with whom they work, using one or two typical children, or even going through their whole group. If the trainer sees this technique as a good one, safety needs to be built into the session, perhaps by not requiring reports to the whole group. Some workers would be comfortable volunteering their findings; others would not.

b. Each group reports on its assigned task: the child, the needs, the activities, and the reason each activity is being used.

7. Final Activity 5 minutes

After all have reported, the trainer can ask participants to write "I learned" statements; volunteers can share theirs, and the session is complete.

ANNOTATED BIBLIOGRAPHY

Foster, Genevieve W., et al. Child Care Work with Emotionally Disturbed Children. Pittsburgh: University of Pittsburgh Press, 1972.

Chapter 12, "Developmental Programming," by Karen VanderVen provides the best discussion of the use of activities that I know of. It correlates the functions of activities with specific psychological tasks, needs, and problems of disturbed children. A good combination of theory and practical examples.

Nahme-Huang, Larke, et al. "Imaginative Play Training and Perceptual Motor Intervention with Emotionally Disturbed Hospitalized Children." American Journal of Orthopsychiatry 47, no. 2 (April 1977).

An interesting, documented description of how appropriate use of activities can alter behavior and help reach therapeutic goals. More readable than the title lets on.

Redl, Fritz, and Wineman, David. The Aggressive Child. New York: The Free Press, 1957. Part II, "Controls From Within."

Chapter 2, "Therapeutic Programming," is a lengthy but essential discussion of programming. The authors raise the crucial issue of worker values interfering with therapeutic goals, discuss the consequent misuse of activities, and describe concrete examples of various goals for the use of activities. Chapter 2 forms the basis for the assumptions of this module along with Whittaker's writing on the subject.

Trieschman, Albert E.; Whittaker, James K.; and Brentro, Larry K. The Other 23 Hours. Chicago: Aldine, 1969.

This essential source book for CCWs contains excellent chapters on both program activities (including an explanation of the dimensions of activities) and the several daily routines. It offers concrete examples and suggestions for dealing with problems.

HANDOUTS

SELF-ASSESSMENT: ACTIVITY PROGRAMMING

What you learn in training and how good that training is are both measured by what you do. If you take the time to fill out this form you will see for yourself what you've learned and you will help the trainer to evaluate the training.

In the appropriate boxes below, respond to the following items. Answer item (a) with a simple "yes" or "no;" for the other items, use the number on the scale that most closely represents your level of activity for each item. Repeat this process at three and six months following training.

a. I can identify four needs of children that can be met by purposeful play.

b. I make it a point to write out a play program for every child, based on his or her needs, abilities, and treatment goals.

c. I attempt to use all activities and routines to their maximum potential for children's growth, rather than as mere management techniques.

1	2	3	4	5	6	7	8	9	10
never		occasionally		sometimes			often		always

	a. Four needs met by play	b. Written play program for each child	c. Use of activities and routines
1. Before training			
2. Three months after training			
3. Six months after training			

Has your training increased your level of knowledge and use of that knowledge? If not, try to determine why; share your thoughts with your trainer.

MINI-CASES

Mini-Case 1

Saturday, when you arrive at 3 p.m. to relieve another worker, he is sitting on the steps with a few of the more active boys in the cottage. As you enter by the other door, you notice two of your boys climbing out of the window of the next cottage. Inside, there are cookie wrappers and crumbs strewn around the kitchen; one boy is sleeping on the couch; you find another lying on his bed rocking.

Task

There are many things wrong with this "picture." What are the most important missing components? Try to be explicit about the reasons they are important.

Mini-Case 2

The twelve boys, eight to thirteen years old, returned to the cottage from school at 3 p.m. Since it was a rainy Monday the child care worker planned an activity that he knew was a favorite of the group - model building. After the group reached the arts and crafts room, problems started - fighting, teasing, misuse of the glue, and so on. It took quite a while for him to settle the boys down. No one finished his project, and the boys went to supper disgruntled and sullen.

Task:

The members of each group are to come up with as many reasons as possible to explain why this activity went awry. Focus on the relationship between the children and the activity. Be ready to report your list to the rest of the groups.

30

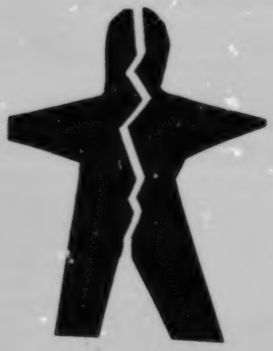
CASE EXAMPLES

1. Gladys, age thirteen, is average size for her age. However, she is considerably behind academically and socially. When left alone she withdraws to her room where she stares or rocks. In games with other girls she is apathetic and tends to quit rather soon, if she plays at all. In general she presents no behavior management problems, but she is teased often by the others. When that happens she retreats.

2. Juan, age fifteen, is an athletic, popular boy, of average intelligence. He has a history of criminal mischief and truancy. At the agency he gets along quite well and has been doing well in the small classes of the residential school. His temper gets the best of him in competition, however. He is easily upset in even the friendliest of games; when upset, he tends to become aggressive and violent.

3. Leroy, age nine, is big for his age. Behind his peers, both academically and socially, he likes to play imaginative-type games at his own or a lower age-level (e.g., trucks in the sandbox). He plays well around other children but not well with them; he doesn't seem to be able to assume the role of partner or a position in a group game. When teased or bothered, he tends to react violently.

4. Lorraine, age nine, is average in size and intelligence. She has trouble in school and in play because she does not stay still long enough to complete much of anything. She gets very enthusiastic about many things; but the enthusiasm lasts only a short time, after which she is off to something else. Most of the girls her age won't play with her, though a few of the older girls have tried to help her out.



Developmental Problems of Adolescence

by *Wayne Ouderkirk*

INTRODUCTION

Adolescents are generally recognized as the most difficult age group with which to work in residential care. The length of time their problems have had to develop or to go unnoticed, their chronological proximity to adulthood contrasted to their emotional immaturity, the difficulty of resolving the common developmental crises of adolescence in a society in transition - these and other factors are cited as explanations for both the fact of residential placement and the reason why adolescents are so difficult.

While not contesting any of these - least of all the difficulty of working with teenagers - this module will not attempt to explain adolescent disturbances. Instead, it will concentrate on the unique factors shared by all adolescents: their developmental tasks. This is not to say that all of the problems of adolescents in care are developmental problems. That would be completely false and, in a child care training curriculum, hopelessly inadequate. What this module assumes is that the other training sessions in this curriculum - including "Human Growth and Development"; "Loss, Separation, and Placement"; "Child Care Practice"; and "Crisis Prevention/Intervention" will provide the knowledge and skills required to deal with any children in placement, including teenagers. This is because, with adolescents as with any children in care, we must know their level of emotional development, their family history, and their history of loss; we must make plans with them, including specific goals and how to accomplish them; we must program for them and deal with behavioral crises.

But because of the special characteristics of adolescents, workers and trainers have seen a need for a separate session on this topic. It must be stressed, however, that anyone working with teenagers needs the basic child care skills presented in the other sessions of this curriculum. So how does this module differ from the section on adolescent development in "Human Growth and Development"? By focusing in detail on two interrelated topics:

1. Adolescent development in general. This is presented in much the same way as it is in the "Human Growth and Development" module, via a fantasy trip, etc. While this is somewhat repetitive, practitioners generally find it useful to remind themselves of significant factors like developmental tasks. (To obviate the repetitiveness somewhat, the fantasy given here is slightly different.) The main difference here is that participants have an opportunity to connect these tasks directly to the child care situation, providing a chance to discover how they influence, for better or worse, the teenager's placement.

2. Moral development. This is discussed in the second part of the resource paper, along with its implications for practice. A large number of teenagers' problems are value-oriented. Knowing how values or "moral knowledge" develop can make interventions more effective, thereby helping teenagers.

There are no magic techniques or answers that "work" with adolescents in care. All that this module hopes to do is to focus on the issues that face such youths because they are teenagers. Helping them in this regard, while not sufficient in most cases to resolve the problems leading to placement, is nonetheless necessary to prepare adolescents for life on their own.

BEHAVIORAL OBJECTIVES

After participating in this session, workers will be able to

1. Identify the four major developmental tasks of adolescence and tell what behaviors and activities indicate that a teenager is attempting to work on a task. This might include some reference to similarities between the workers' own generation and the present teenage group.
2. Tell how residential placement can heighten and/or diffuse the problems generated by adolescent tasks.
3. Tell what they can do, as child care workers, to diffuse or ease the difficulty of each developmental problem for the teenager with whom they work.
4. Identify the three levels (six stages) of moral development, identify their own stage, and identify the stage of each teenager in care.
5. Devise a value or moral dilemma for each teenager in their care to discuss.

BEHAVIORAL CHANGES

1. Participants will be more aware of the developmental problems of adolescence. This will be evidenced by their mentioning such issues in logs, reports, and team conferences.
2. Participants will attempt to develop programs that allow the teenagers in their care to experience such developmental problems in a constructive, appropriate manner.
3. Participants will be more aware of the value development of their charges. This awareness will be manifested in logs, reports, etc., and in the form of programs to encourage such development. Such programs may be either informal but deliberate and planned by the worker (e.g., rap sessions with residents about values issues) or formal (e.g., moral development discussion groups with pretests, etc.).

RESOURCE PAPER: DEVELOPMENTAL ISSUES OF ADOLESCENCE

Introduction

Perhaps no other age group has been so written about, so scrutinized, or so misunderstood as teenagers. Hardly a year passes without a national turmoil about some new problem discovered among teenagers. No book on human development passes over adolescence lightly; indeed, many books and at least one journal are devoted solely to the study of adolescence. Few parents look forward happily to their children's teenage years. Conversations of each succeeding generation abound in worried wonder at "today's" teenagers. Those who work with teenagers often reach out to other experts for answers.

This paper cannot hope to resolve the problems or give "the answers" about adolescence. What it will attempt is to describe a useful framework for viewing adolescent development. It is the opinion of many professionals that most - but emphatically not all - of teenage problems that adults generalize about are related to one or more of the tasks of adolescent development.

For child care workers, the developmental tasks are certainly not a complete picture of the adolescents they see. In addition to these tasks, each adolescent faces other huge difficulties - disorganized or disintegrated families, drug or alcohol abuse or addiction, irresistible violent impulses. In residential treatment, the developmental tasks serve to complicate other, more long-standing problems. Those other problems require serious examination and intervention; and there is an ever-growing body of knowledge about them. The focus here will be on development because that is what is uniquely adolescent about the youths in residential care. The skills child care workers require to work with teenagers are the general skills of child care discussed in many other places. Here we will examine adolescent development to see how it can be used to advantage. The discussion will be divided into two parts: (1) a brief recapitulation of all the developmental tasks of adolescence and (2) a discussion of moral development.

Adolescent Development

The most definite thing many people can say about adolescence is that it is a time of turmoil, of difficulty, of adjustment - a lengthy traumatic period from twelve through twenty that we all must experience. Even this generally accepted notion is challenged by researchers:

> ...we may be giving up the illusion that there is one single adolescent psychology, timeless and universal. One sign is that we are beginning to make age distinctions within the adolescent period, beginning to discover what vast differences are to be found among early, middle, and late adolescence.[1]

Whatever the final conclusion of researchers as to what is peculiar to the stages within adolescence, it seems clear that we cannot limit our view of adolescence to Erikson's single task of achieving one's identity. (Indeed, in one sense, identity is forged throughout life.) There is just too much going on in adolescence for us to characterize it adequately as the search for identity.

Moreover, if Adelson is right, we also have to change our view of adolescence as a traumatic time:

> If we examine the studies that have looked fairly closely at ordinary adolescents, we get an entirely different picture. Taken as a whole, adolescents are *not* in turmoil, *not* deeply disturbed, *not* at the mercy of their impulses, *not* resistant to parental values, *not* politically active, and *not* rebellious.[2]

Of course, this does not mean that the teenagers in residential care are not troubled. But it does reinforce the earlier claim that their problems are not necessarily the problems of adolescent development. This view of adolescence opens the way for the child care worker to use the tasks of adolescence to give teenagers in care an opportunity to experience this period of development in a positive way, to work through the tasks happily and constructively. For example, though a particular teenager may be in placement because of his family's long history of breakdown and disorganization, he may be able, with help and patience, to achieve a solid independence, along with positive feelings about himself. Thus, he can still accomplish one of the tasks of adolescence - achieving independence - without the task being a traumatic one. Of course, the child care staff must see to it that there is a program adequate to his accomplishing that goal. The point is that many adolescents in residential care can experience that time of life as positive and enjoyable. Indeed, both agency and child care worker should see that this opportunity is provided.

Before examining the tasks of adolescence, we should say something about earlier developmental tasks. It is one of the cardinal tenets of Erikson's psychosocial developmental theory that if an early developmental task is poorly resolved or resolved in a negative way, resolution of subsequent tasks will be hampered, if not prevented, by that lack of resolution. As child care workers know, many adolescents in care have not worked through those earlier issues. Primary among their liabilities is a lack of trust. Obviously, the task of the worker and of the whole team is to help these youths gain a sense of trust so that they can enter into positive relationships.

The upshot for child care workers is that they have to find ways to help teenagers resolve several developmental tasks, including those of adolescence, in a short period of time. The adolescent tasks cannot be postponed; and issues such as trust need to be addressed. All this results in a difficult task, but a task that the child care worker and the rest of the team can at least begin. The first step is to determine what issues the child needs to resolve. If one issue, for example, is trust, then trust must be gained in a manner appropriate to the teenager, who, at least in his own eyes, is no longer an infant. It is something of a juggling act, to be sure, but it has been my experience that child care workers are expert jugglers.

Developmental psychologists disagree over the number of tasks to be accomplished during adolescence. The viewpoints range from Erikson's single one, identity vs. role diffusion, to the Newmans' eight specific tasks.[3] Whatever the most adequate theoretical formulation of what we call adolescence turns out to be, however, it is useful for child care work to group the various tasks under four headings:[4] physical maturation (i.e., the psychological accompaniments of that maturation); relationships, both heterosexual and peer; independence; and identity. One thing to notice about these categories is that they are not mutually exclusive. That is to be expected, since we are discussing issues that may exist simultaneously.

1. Physical maturation. That there is a great deal of physical change during adolescence is an obvious fact. Two interrelated factors, bodily growth and sexual maturation, have a great deal of significance for other areas of a teenager's life. Individuals often experience rapid spurts of growth during adolescence. This sudden change in physical stature can change one's self-image and consequently one's social interactions.

   Since size can be mistakenly equated with maturity, there are two possible psychological results. First, when a youth grows rapidly and begins to be treated as older, it can have a positive effect on his self-esteem. His responses can be to accept and thrive on this new, "older" role - provided those around him do not overwhelm him with expectations. That would lead to the second response. If the expectations of emotional maturity are too great, the teenager can react by trying to out-adult the adult. Often what we label as immature behavior is exactly that: an attempt to be too mature - for example, excessive alcohol consumption.

   The adolescent who matures later physically has to deal with the opposite problems. At times people may treat him as younger than he is; so he has to prove he is as old as his age. We all know that this effort can be expressed as a negative behavior. Another result of late maturation can be isolation from peers or feelings of inadequacy. When peers get much bigger much faster it is not surprising that feelings of inadequacy overwhelm a youngster.

   Sexual maturation usually accompanies the physical growth of adolescence. It can mark the onset of sexual impulses that the child has never experienced before. Without information and support, these impulses can be confusing and disconcerting. They may be equated with the individual being "weird" and different; they may also be seen as evidence of lack of control over one's own body. Further value judgments can result in the person's feeling bad or evil as a result of these natural bodily developments and impulses.

In contrast, with some help in putting sexual growth in a natural perspective, the teenager can accept this change happily and learn appropriate responses to his or her impulses and curiosity. The appropriateness is partly determined by the social setting - parental and cultural values and so on - and partly by the individual's attempts to fit into that setting.

Since teenagers in residential care face both physical and sexual maturation, child care workers need to be aware of the issues these factors raise, both positive and negative. It is easy amid the whirl of activity of an adolescent child care unit, to lose sight of such things because of more immediate problems. But workers can find ways to attend to physical/sexual issues.

For example, actually encouraging residents to look at themselves privately - head to toe - once a day and to praise their physiques can go a long way toward developing positive self-image. Workers need to help the faster growing teenagers act like kids sometimes, since size so often places them in group-leader roles. Sexual development remains a difficult and sometimes even taboo issue in many agencies. Still, it is the worker's duty to provide a positive context for that development. Without that context, the issue will "submerge" and come out in negative ways. Workers can provide age-appropriate material that can help inform the residents. In addition, being informed oneself and being open enough to share that information in discussions and "rap" sessions is probably a sine qua non of working with adolescents. And in many agencies, sex education programs are being developed.[5] (The social dimension of sexual development is discussed below, under relationships.)

2. Relationships, heterosexual and peer.* A more inclusive label for this task might be "the development of social skills." Still, that does not actually capture the essence of what is happening at this point. Before becoming teenagers, children have social skills. The issue facing them as they get older is to begin developing those skills into adult skills. Thus, there arises the need, not necessarily pressing prior to this, of differentiated relationships between the sexes. (Although this may well be a culturally determined need, it doesn't seem to be entirely so.) The youth must define who he or she is vis-a-vis persons of the

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* Of course, peer relationships may include heterosexual relationships. The two are contrasted here to emphasize the adolescent's task of finding his or her place in relation to both the same and the opposite sex.

opposite sex - how to relate to them, how to treat and be treated by them, etc. And the same for members of the individual's own sex - how to act around them, what to do together, and so on. Insofar as this task is one of achieving a sex role identity, it is part of the identity task. The aspect being stressed here is the social one.

Part of the peer-group element involved in this task takes the form of membership in cliques, small groups of individuals of about the same age who share many interests and traits. Cliques are often comprised of members of the same sex. Among teenagers arriving in residential treatment, it is often found that this task was being accomplished by street-gang membership, something that presents difficulties other than developmental ones. If the boundaries of a clique are too rigid, the group can become insulated from ideas and values different from its own. Anyone who deals with teenagers needs to be aware that such insulation can lead to undesirable consequences for the youngsters, not the least of which is narrow-mindedness. They need to be encouraged to consider many different activities and interests.

With the exception of such cliques, teenagers need to conform to peer group norms and values, including dress codes, musical tastes, and activities. For the first time in their lives they have the need and the desire - and hence require the opportunity - to choose such things for themselves, to distinguish themselves as a group separate from but continuous with, and in their eyes equal to, the adult world.

Nonacceptance by a group or clique can lead to alienation and depression. Peer-group acceptance is so important for teenagers that some theorists have identified it as a separate developmental stage with its own crisis and resolution.[6] It seems clear then that any adult dealing with a teenager should see to it that the teenager finds an acceptable group with which to identify.

That adult responsibility itself can lead to problems. Everyone is familiar with the perennial conflict between teenagers and the adults responsible for their care over the suitableness of their companions. There is of course no answer as to who is right in this conflict. Without doubt, it is essential that the teenager have some say in the choice of companions. Unless this is so, resentment or rebellion becomes unavoidable.

What constitutes appropriate relations between male and female teenagers is a changing and always controversial subject. It seems clear that adolescents must have accurate information about sex, as well as the opportunity to interact socially with members of the opposite sex. Without accurate information incorrect and destructive attitudes can form; without accepted social interaction no development toward adulthood is achieved.

The fact that girls often mature physically more quickly than boys can cause problems for either sex. A girl who matures quickly may feel strange, alienated, and overwhelmed; a boy who matures less quickly may feel inadequate; each requires appropriate adult assistance.

Child care workers must find appropriate ways to deal with developmental problems related to the friendships and sexual identities of teenage residents. Although these issues are many times problematic because of the youths' emotional immaturity, they are nonetheless real, and workers can structure the environment so that the teenagers can experience them positively. By providing teenagers with dances, outings, teen centers (in larger institutions), and other group activities, many agencies go a long way toward creating a natural adolescent experience. Those in placement benefit by participating in acceptable, enjoyable adolescent pastimes in the community. Horizons are widened and acceptability is reinforced by others in addition to the child care workers; the large peer group exerts its influence. Typical peer-group activities, like sports and concerts, and typical heterosexual activities, like dances, are both included here.

This is not to underemphasize the difficulty many teenagers in residential centers have in behaving appropriately in social situations. Workers and agencies should allow such teenagers to experience social situations in ways that allow them to be teenagers. That means they must socialize with both peer groups and members of both sexes.

3. Independence. The questions that inevitably arise regarding how much freedom teenagers should have to socialize relate to another of the four major developmental tasks, independence. Those questions emphasize that the four issues are not separate in actuality. Although we can isolate each for purposes of discussion, aspects of the others creep into our discussions. Independence does not denote complete self-sufficiency; it is questionable whether anyone is capable of that. Rather, in the present context, we indicate by independence the transition to the adult role. This is a huge and significant task for the adolescent, who must balance feelings and desires within herself or himself that are in direct conflict with one another: the desire to separate from and cease dependence on the parent (adult) world versus feelings of dependence and the desire for security. No wonder teenagers often baffle us by fluctuating between "I can do it myself!" and "Please help me!" In confronting this developmental task - which is conveniently seen as increasing in intensity from early to late adolescence - the teenager begins to consider vocational choices and to develop skills for independent living. The traditional after-school part-time job is a tremendous aid to this process, providing an opportunity to try out an adult model while accepting adult responsibilities. Though such jobs need not be seen as voca-

tional choices, they do help teenagers define their options and preferences.

Another aspect of the quest for independence is the process of developing one's own values and morals, a subject that will be examined in depth below. One of the more disconcerting parts of this search for values is that it is coupled with the teenager's newfound ability to reason abstractly. The result is that the adolescent begins to challenge the adults' values and actions. There is a tendency to be very idealistic and to regard any deviation by the adult from expressed values as sheer and inexcusable hypocrisy. Parental flaws are minutely scrutinized and contrasted with ideals. Adults don't like that.

Overall, the quest for independence is a positive move toward adulthood. There are problems, though, besides the one just noted. For one thing, although they are becoming more adult, adolescents still do not have many of the privileges of adults. Indeed, such limitations are many times reflected in laws (and for good reason). Also, adults can expect a teenager to make decisions, but the teenager is still immature. That means he or she will sometimes make the *wrong* decision. That possibility has to be allowed for. Again, in striving for independence, some youths may exhibit hostile and frantic behaviors.

How much independence to allow a teenager may be a more difficult problem for the child care worker than for parents. The worker must contend with multiple and sometimes conflicting viewpoints. Agency policy must be followed, community standards upheld; the teenager's own capacities and needs, including the need to fail, must be accepted and dealt with; there must be ample opportunity for the teenager to try out many different roles; and the rest of the children with whom the teenager lives may have a different level of ability than he has to take advantage of independent activities. Without even considering the other problems teenagers might bring to residential care, then, we can see that dealing with the issues of independence is a formidable task for the child care worker.

However, it can be done, and done appropriately. Exposure to many different activities, occupations, and places assists teenagers in thinking about career choices. Opportunities to shop for clothes and food introduce him to the complexities of independent living, as does a part-time job along with chores in the cottage or unit. Appropriate privileges can be rewarded in proportion to responsible behaviors and attitude. When the teenager makes a mistake in decision and behavior, he must have the opportunity, after reflection and discussion, to try again.

4. *Identity*. All of the tasks of adolescent development are related to the task of achieving one's own identity. Erikson considers this *the* adolescent developmental task. We have already ex-

amined many of the questions that can be grouped under this category. We shall limit this section to other considerations.

If a younger teenager can be said to be concerned with a peer-group identity, the older teenager can be viewed as beginning to see himself as different from peers. This can be upsetting since the peer group is such an important part of adolescence. The realization that one is different from those formerly perceived as resembling oneself is hard to face.

Another facet of achieving one's identity is the self-analysis and introspection required. Sometimes this is disconcerting to those around the adolescent because there is a real egocentricity involved. The teenager sometimes even literally says, "Everybody is watching me!"

In the discussion on independence, trying different roles was mentioned. This is a link to the problem of identity, because discovering which role "fits" is a highly significant component of adolescence. Obviously, this discovery of the right role can be achieved either positively or negatively. On the positive side, the teenager can take steps to develop one of many socially acceptable roles. Negatively, he or she can refuse any socially acceptable role and become alienated, delinquent, and so on. This is not to say that such refusal is the only or main cause of alienation or delinquency. Rather, the claim is that such results are the signs of a lack of achieving a positive identity.

One cultural factor for American teenagers is the postponement of the need to achieve an identity until after college. Thus, some writers have extended the period of adolescence until age twenty-two.[7] Whatever age one wishes to use to demarcate adolescence from adulthood, it is clear that it is possible to view all of life as a quest for identity. The significant factor for teenagers and for those who work with them is that adolescence contains the first independent step toward that effort.

Child care workers assist youth in seeking an acceptable identity by providing and encouraging suitable school programs and performance and by encouraging the taking of responsibility through incentive and reward structures and activity programs, including sports, arts and crafts, and so on. A relatively recent but very powerful aid to all such programs is participation in such ventures as Outward Bound, which forces those who participate to confront themselves and their self-created limitations and obstacles to achieving goals of any kind.

Encouraging teenagers in residential care to seek a personal identity involves the child care worker in many of the same difficulties as dealing with the other tasks we have discussed. As is the case with those other tasks, so it is with this one: for the teenager's sake, it must be done.

Moral Development

Running throughout the several adolescent developmental tasks are issues of values. As illustrations of that fact we may imagine the adolescent asking the following questions: How should I deal with these sexual feelings I have? Who are the right friends? Why should I act the way my parents want me to? What would I like to do with my life? These questions respectively concern the four developmental tasks of adolescence discussed earlier in this paper. They are all value questions. This part of the paper will focus on value development and how it too can be utilized in the child care milieu to help adolescents grow. First the paper will present Kohlberg's stage theory of moral development; then it will discuss the theory's implications for child care (and other child welfare) workers.

Lawrence Kohlberg is a developmental psychologist who has studied moral development for over twenty years in many different ways.[8] The results of this continuing research is his schematization of moral development into a sequence of stages through which we all progress.[9] No effort will be made to recapitulate that research; only the primary technique used is needed to explain how he arrived at his classification.

Kohlberg presented hypothetical moral dilemmas, tailored to the age-level of the subjects, to elicit the kind of answers and reasoning different people would give in response to the given problem. A dilemma presents one with a problem situation which cannot be answered simply, since whatever answer is given results in consequences that are hard to accept.

For example, one of Kohlberg's dilemmas is the following (presented in general terms): Imagine that your loved one has a fatal disease, the cure for which was recently discovered. Imagine also that the discoverer refuses to sell the drug for any amount less than five million dollars (or any exorbitant sum you'd like). He is resolute and impervious to your pleas; you are out of funds and credit. The question is, Would you steal the drug to save your loved one's life? More importantly, *why* would you choose your response? If you steal it, you'll be caught and probably jailed. If you do not steal it, your loved one dies. Either way, the choice is difficult.

Kohlberg gathered a huge number of responses to this and other dilemmas. Upon examination, the responses fell into a pattern of moral development. This pattern has three levels.[10] On the *preconventional* level, the individual is responsive to cultural norms and labels about right and wrong, good or bad, but interprets them in terms of either physical consequences or the physical power of those enforcing the rules. The *conventional* level also includes conformity to group or cultural norms; to this conformity is added loyalty, the effort to maintain those norms regardless of the physical consequences.

Finally, at what Kohlberg calls the postconventional level, the individual attempts to define moral principles that apply, whether or not the individual accepts them. Before examining the levels and stages more closely, we must note an important aspect of the postconventional level. In order for someone to achieve this level of moral development, he or she must have reached what Piaget calls the "formal operations" level of cognitive development.[11] Very roughly put, formal operations means the ability to think abstractly.[12] Without that cognitive ability, says Kohlberg, a person is not able to reach the postconventional level. However, ability to perform formal operations does not in itself place a person on the postconventional level of moral development. Put technically and precisely, formal operations ability is a necessary but not sufficient condition for postconventional moral thinking.

Each level has two stages. On the preconventional level, stage one is the reward-punishment orientation. A person at this stage believes right or wrong is determined by the physical consequences of the act. Doing good is equated with avoiding punishment or physical destruction. An illustration of this comes from Kohlberg's dilemmas. We ask a child whether Johnny did wrong by opening a door, thereby breaking fifteen cups that he didn't know were behind the door, or whether Jane did wrong by accidentally breaking a cup while stealing forbidden cookies. The child at stage one says that Johnny, who broke fifteen cups, was worse. Obviously, the intentions of the cup-breaker do not enter into the reasoning here.

Stage 2, still within the preconventional level, is called the instrumental orientation. A person at this stage describes whether an act is right or wrong by the instrumental satisfaction of his or her needs. Kohlberg uses a marketplace analogy for this stage. The person wants to know, "What's in it for me?" An example is from Tom Sawyer. Tom is painting the fence, but convinces his passing friends that he's having a lot of fun. His friends are conned into joining him, but it costs them their prized possessions - frogs, toys, etc. - for the privilege. Tom is willing to share his "good fortune" but wants to get something in return. A better example from a child care standpoint is something that happens when children begin to "buy into" whatever system we use to run our unit. They begin to see that going along with the rules can pay off for them. Although that is not the only reason we'd like them to have for accepting the structure, it is a start, perhaps the only start of which they are capable.

Kohlberg calls the first stage of the conventional level, stage 3, the good boy-nice girl orientation. The approval of others determines the rightness or wrongness of an act for someone at this stage of moral development. Something is good if it pleases important people, otherwise it is bad. This stage is thus characterized by conformity to majority or "natural" behavior. Also, intentions can play a role in the justification of an action.

An anecdote from child care will illustrate this stage. A teenage boy in a staff member's cottage had just given another staff member a lot of backtalk, some of it obscene and all of it uncalled for and well below the boy's potential. The first worker told the boy that he thought the boy was out of line and owed the second worker an apology. Of course, the boy disagreed, vowing never to apologize to "that so-and-so!" But the next day, the boy took the first worker aside and informed him that he had apologized after all. When the worker asked him why, the boy responded, "I did it for you." He had given no thought to the other worker's feelings, to the inappropriateness of the behavior, only to his relationship with the first worker. Such an action, of course, is not without its positive aspects from a child care viewpoint (a developing relationship with an adult, etc.). This is not to downgrade those aspects, only to illustrate the good boy-nice girl orientation.

Stage 4, now called by Kohlberg the system-maintaining orientation, is the second portion of the conventional level. As with the previous stages, there is conformity to authority, but now the person also makes efforts to maintain the social order. One must do one's duty, respect authority, and preserve the system, which is seen as good in and of itself. Archie Bunker is a good example of this stage.[13] He believes that there is one and only one way to do anything, from running the country to putting on one's socks and shoes in the morning. Perhaps a better illustration of stage 4 is the character Karenin in Tolstoy's Anna Karenina. When his wife Anna admits to him that she is having an extramarital affair, his response is totally system-maintaining. He is upset because his wife has violated the rules of their social class, because of what people will think, and so on. It is telling that he never raises the issues of trust, of love, of their relationship. There is some evidence of this stage among teenagers in residential care. Youths have been heard to tell newer residents to follow the rules, that the rules are important. These, however, have been teenagers who were well advanced in the program. This leads to the conclusion that the remarks can be characterized as stage 4.

Moving now to the third or postconventional level, we come to stage 5, the social contract orientation. At this level, we find for the first time what we would call moral reasoning in a strict sense. Right and wrong are defined here in terms of general individual rights and standards, which are agreed upon by society. There is allowance for the relativity of personal values and opinions and the acceptance of procedural rules to reach consensus in cases of disputes. (Contrast this with stage 4, where there is only one way to do things, the status quo way.) There is allowance also for the change of rules and laws via rational considerations. The paradigm of this kind of orientation in thinking is not a person, but a document, the United States Constitution, which can be seen to possess exactly those characteristics used to define stage 5. Though it would indeed be surprising to find examples of this stage among the children in residential care, there are examples of it among the workers. Perhaps each of us has, at one time or another, appealed to the rights of the other children while correcting the behavior of one of them. That is a stage 5 appeal, about which more will be said later.

Kohlberg's final stage is the universal ethical principles orientation.[14] The person at this stage of development makes an effort to discover comprehensive, universal, and consistent principles to which an act must conform or at least not violate. As examples of this stage, Kohlberg has used the appeals made by Thoreau, Gandhi, and Martin Luther King to justice as a principle, which they saw as higher than the law and which they were called to follow.

That, in very sketchy terms, is the stage theory of moral development that Kohlberg has proposed as an outcome of his research. Some of the characteristics of the theory have important implications for child care practice, both in general terms and in terms of a specific possibility for group work.

First, the various orientations are called stages because the research indicates that they occur in an invariant sequence.[15] That is, everyone goes through the stages in the same order. Thus, if we can find out at what stage someone is functioning, we can know what is the next stage he or she can enter. Kohlberg's research tells us that we can indeed know where someone is in the stage sequence.

Secondly, the research also indicates that the person understands the reasoning of all previous stages and the reasoning of not more than one stage beyond his or her own stage. What this factor means is that if we want a person to move forward in terms of his or her moral development, then we must present the issues involved in a moral problem to that person only in terms of the next higher stage. Kohlberg holds out hope and optimism to us. He says that findings strongly indicate that the individual prefers the next stage.

Now many of the problems faced by children, adolescents, and child care workers in the context of residential care are value or moral issues. In the opening paragraph of this section, some examples illustrating this claim were given. In those and many other situations, the level of moral development being exhibited in the decisions or responses is less than it could or should be. Put differently, we would like to see the individual move forward in that area. The main problem arises regarding how to do it.

Any child care worker knows that an attempted intervention must be performed at the child's level of functioning so that he or she can utilize that intervention. Applied to moral development, and using Kohlberg's own description of a stage theory, this means that we cannot ask a child - or anyone else - to accept reasons more than one level beyond that person's present level. For example, a teenager who is prone to stealing from roommates and who is in stage 2 (instrumental orientation) will not respond to a stage 5 appeal from the child care worker. It is not because the youth disagrees or refuses to listen or listens and then rejects the appeal to others' rights. According to Kohlberg's picture, he does not respond because he cannot understand the appeal. Instead of making the stage 5 appeal, the worker would do better with a stage 3 approach, based on the youth's group, setting, treatment plan, and relationships with staff.

What this kind of intervention amounts to is the teaching of moral judgment, something that has been out of style for many years. But Kohlberg's approach does not include dictating the right answers, to be learned by rote by the young person. That approach has been thoroughly discredited.[16] However, that does not mean that we cannot teach moral judgment. It is a great merit of Kohlberg's theory that it explains both why the traditional technique failed (because the values being taught were more than one stage ahead of the pupils' stage) and how to go about stimulating moral growth.

In order to help stimulate anyone's development, we must first be sure of what stage he or she currently is in. One integral part of child care workers' professional repertoire is listening. If a worker tunes in on a teenager's discussion of values issues - and such discussions are hardly rare - and classifies the reasoning into corresponding stages, after a time a pattern will emerge. Most of the responses will be in one stage; if not, it means that the youth is already in a transition between stages. This part of teaching moral judgment corresponds to the first step of all other aspects of the helping process: assessment.

After assessing the stage, the worker has to use a principle common to all developmental theories. Speaking generally, in order for subsequent growth to take place, a disequilibrium, an imbalance, a decentering, has to take place; the individual must come to see that his or her current adaptation to the world is inadequate to some degree. In moral growth terms, this means that the worker must create some dissatisfaction with the teenager's present knowledge of moral reasoning. The key to this is exposing his or her values to conflicts for which his or her current orientation does not have a ready answer.[17]

There are many ways to accomplish this exposure. Formal discussions of everyday events is one way; values clarification literature provides many exercises that force one to think about values choices and can be adapted to informal discussions.[18] An additional technique is the creation of a moral-discussion group. Kohlberg and others have found that the most effective way to "move" someone forward is to expose that person to disagreement and argument with peers.[19] Organizing and maintaining such a group in a residential facility would be a large task for a child care worker. However, it could be done, especially with the aid of a clinical or developmental psychologist. It would have to include initial assessment of participants as well as extensive preparation by the leaders.[20]

A final factor important for moral growth is the moral atmosphere of the institution.[21] Integral to the institution's moral atmosphere is the level of justice practiced therein. Arbitrary, capricious, overly rigid, overly permissive - because institutions are human, these negative characteristics can creep into our practice; so we must be sure to guard against them by constantly reexamining our structure. By doing so, by openly evaluating residents' criticisms, we can be sure that our institutions practice a high level of justice. The other part of the moral atmosphere is providing residents with the opportunity to take on a variety of roles. Not role playing, but role taking. This relates to the developmental tasks discussed in the first part of the paper, where we saw that teenagers need to have such opportunities in order to achieve a resolution of their developmental crises. Role taking enables youths to see things from a variety of perspectives, and thus it promotes more reflective judgments.

Whether a worker chooses to organize a formal group or not, moral and values issues constantly confront the adolescents in placement. Because of the child care worker's professional role, he or she must provide help and guidance to these teenagers in facing these issues. To that end alone, Kohlberg's theory provides invaluable aid.

References (see p. 333-34 for full listings)

1. Joseph Adelson, "Adolescence and the Generalization Gap," p. 37.

2. Ibid.

3. Barbara M. Newman and Philip R. Newman, "Early Adolescence and Its Conflict," pp. 261-274.

4. Anne Stea originated this grouping, which has worked quite well in training contexts.

5. For a description of a sex-education program in a residential treatment program, see Cecilia Owen Beckham, Lon Johnston, and Ernest Beckham, "Sex Education for Children in a Residential Center," pp. 393-402.

6. Newman and Newman, pp. 260-274.

7. Ibid.

8. Kohlberg presents his views on his theory and its implications in a number of articles. See "Moral Education for a Society in Moral Transition," Educational Leadership, October 1975, pp. 46-54; "Moral Development and the Education of Adolescents," in Adolescents and the American High School, R.F. Purnell, ed. (New York: Holt, Rinehart and Winston, 1970),

pp. 144-152; "Moral Education in the Schools: A Developmental View," in Adolescent Behavior and Society: A Book of Readings, Rolf Muuss, ed. (New York: Random House, 1971).

9. Howard Muson, in "Moral Thinking: Can It Be Taught?" pp. 48ff, gives an overview of Kohlberg's theory, criticisms of it, and attempted revisions. For detailed criticisms, see William Kurtines and Esther Blank Greif, "The Development of Moral Thought: Review and Evaluation of Kohlberg's Approach," Psychological Bulletin 81, no. 8 (1974).

10. See the handout on pp. 339-40, quoted from Lawrence Kohlberg, "Moral Development and the Education of Adolescents," pp. 148-149.

11. Kohlberg, "Moral Education," pp. 48-49. For greater detail see Kohlberg and Carol Gilligan, "The Adolescent as Philosopher: The Discovery of the Self in a Postconventional World," Daedalus 100 (1971), pp. 1051-1086.

12. For a clear discussion of Piaget's cognitive development theory, see Henry Maier, Three Theories of Child Development, (New York: Harper and Row, 1969), Chapter 3, pp. 81-158.

13. Kohlberg now disagrees with this example. See Muson, p. 57.

14. In response to criticism - his own and others - Kohlberg has recently dropped stage 6. See Muson, p. 57.

15. A more detailed discussion of the characteristics of a stage theory is given in Kohlberg, "Moral Development," or Kohlberg and Gilligan.

16. Kohlberg contrasts traditional methods of teaching moral reasoning with his own proposals in several articles, including "Moral Development."

17. See Kohlberg, "Moral Development," pp. 158-161.

18. See the module, "Values, Values Clarification, and the Child Care Worker," p. 47 of this curriculum. The bibliography on p. 58 lists values clarification sources.

19. Kohlberg, "Effects of Classroom Discussion upon Children's Level of Moral Development," Recent Research, Lawrence Kohlberg, ed., 1974.

20. Reprints of articles by Kohlberg and others, as well as scoring manuals, etc., are available from The Center for Moral Education, Roy E. Larsen Hall, Harvard University, Cambridge, Mass. 02138.

21. Kohlberg, "Moral Education," p. 53.

SESSION OUTLINE: DEVELOPMENTAL PROBLEMS OF ADOLESCENCE

Time:	About 3 hours, 30 minutes
Space:	Room for large group; places for small groups to work
Equipment:	Easel pad, stand, markers
Materials:	"Adolescence: Fantasy Trip," p. 331 Handouts "Self-Assessment: Adolescent Development," p. 336 "Small Group Task," p. 337 "Tasks of Adolescence," p. 338 "Stages of Moral Development," p. 339

1. Introduction — 10 minutes

The trainer distributes the "Self-Assessment: Adolescent Development" handout and asks participants to respond to the statements by filling in the "before training" boxes. The trainer explains the importance of participants' repeating their self-assessment at three months and six months after training, then returning the completed form with their comments to the trainer.

The trainer introduces the session, pointing out the importance of developmental tasks for any age, especially for adolescence. The objectives are shared in summary form with the participants and any additional ideas participants have are incorporated into the objectives. Emphasis is placed on the positive aspects of adolescence.

2. Fantasy Trip — 40 minutes

The trainer introduces the idea of a fantasy trip. Its purpose is to put participants in touch with their personal experience of adolescence: how they felt, how they acted, what crises they faced, what was popular, who they hung out with, etc. The trainer must provide protection for the participants during this exercise. To that end, he or she must outline the process ahead of time: "The lights will be dimmed, there will be no interruptions; get comfortable, relax, close your eyes; I'm going to ask you some questions; your responses are private...." After preparing the participants and setting the mood, the trainer asks the fantasy trip questions, allowing a moment or two for the listeners to respond to each. (The questions focus on the four major developmental tasks of adolescence, which are described on pp. 315-20 of the resource paper.)

After finishing the questions, allowing a little more time for nostalgia, the trainer gradually brings participants back to reality by brightening the lights, then asking each member to pair off with someone with whom he or she is comfortable to talk about the fantasy.

After five minutes more, the leader solicits comments about it from the whole group, recording them on the flip chart.

3. Small Group Activity 40 minutes

a. Dividing the group into smaller task groups, the trainer then distributes the "Small Group Task" handout and assigns each group two of the topics on that list to discuss. Each group is to record findings as to how issues about its two topics are the same or different for teens today as compared to the members' own teenage years. Each group should choose a reporter to present the findings to the whole group.

b. Each group then presents its comparisons to the others. Discussion is encouraged.

4. Presentation on Developmental Tasks 20 minutes

Using the material in the resource paper as a basis, the trainer presents the four major developmental tasks of adolescence. Throughout this lecture, the trainer can make reference to both the fantasy trip, which was designed around the four tasks, and to the comparison of adolescence then and now, for examples and illustrations. It is also helpful to use child care examples. The emphasis should be on the positive resolution of these tasks. Since participants have been focusing on these tasks for most of the session, the lecture can be short; the handout on "Tasks of Adolescence" can be used to facilitate the lecture.

BREAK 15 minutes

5. Moral Development: Individual Exercise 30 minutes

The trainer introduces the concept of moral development and explains its relevance to working with adolescents. Then, after explaining how Kohlberg arrived at the classification in his theory (questioning about moral dilemmas), the trainer presents the group with the dilemma involving the fatally ill loved one and the person who owns the cure (see p. 321 of resource paper). Each participant is to answer privately the questions, "Would you steal the drug? Why or why not?" Five minutes are allotted for that response, after which participants can discuss the dilemma in small groups, in the large group, or both. The trainer can pick some different responses to the dilemma as illustrations of different kinds of moral reasoning. Care should be taken in doing so, since it is easy for discussions of development to characterize later stages of development as better than earlier ones. Feelings can be hurt in such situations.

6. Lecture: Stages of Moral Development 30 minutes

The trainer presents Kohlberg's stages, using general examples and especially examples from child care to illustrate each orientation. The

32~

last part of the lecture is devoted to drawing out the implications of the theory for working with adolescents.

7. Small Group Activity 15 minutes

a. After the group is divided into five subgroups, the trainer assigns each group one of the developmental tasks of adolescence (moral development is the fifth). Then each group is to focus on its assigned task and:

(1) Discuss how residential care in general and child care workers in particular can heighten problems regarding the resolution of that task.

(2) Discuss how residential care in general and child care workers in particular can diffuse problems regarding that task.

The groups should record their findings and pick someone to report to the large group.

b. The groups report to one another, sharing ideas and insights. Discussion may be included after each report or at the end.

8. Summary 10 minutes

The trainer repeats the objectives of the session and checks to see whether participants feel that they have been met. Then participants write "I learned" statements, volunteers share theirs, and the session is ended.

ADOLESCENCE: FANTASY TRIP

1. Go back to your teenage years; remember your high school, your group of friends, your steady dates - all those things - your favorite music, movies, places to be.

2. Focus in now - remember what your body looked like?

   - Were you proud or ashamed of your body? Why? What was it that made you feel that way?
   - Remember how you rated your body in comparison to others?
   - And how your ideal body would look to your friends?
   - And how your ideal body would look to the opposite sex?

3. What about your friends?

   - Who were they? Did you have a lot or a few?
   - Was one special to you? How?
   - What did you and your friends do together? Were you a clique? A gang?
   - Were you involved in school activities or outside clubs? What ones?

4. Did you have any friends of the opposite sex?

   - Were they friends or were they boyfriends or girlfriends?
   - What did you do with each other?
   - Did you date? Remember your first date(s)? Your prom?
   - Remember your first kiss? How did it feel? Whom did you tell?
   - Remember your first steady or serious date? How did you feel about him or her?

5. How late did you stay out?

   - Did your parents have curfews? Did you think the curfew was too early?
   - How did you see your parents? Were they your friends? Or your enemies?
   - What did you get from them you really liked? What did you get from them that you didn't like?
   - Did you tell them about what you did?
   - Did you tell them about your friends?
   - Did they like your friends? Your dates? Your steady?
   - Did you ask them about sex? Did they tell you about sex?
   - Was sex a reality unspoken between you?
   - Could you tell them about your first kiss?
   - Could you tell them about your date?
   - Could you tell them about any other sexual experiences?

6. Did they help you feel like an adult?

   - Did they teach you to drive?
   - Were you close to one? Or both?
   - Did they push you toward college or a career?
   - Were they interested in your school life?
   - Did they help you to get a job?

7. Did you know what career you wanted? Which one?

   - Or didn't want?

8. Were there heroes to copy or admire?

   - Who were they?
   - Did your friends like them, too?
   - What seemed most important to you?

ANNOTATED BIBLIOGRAPHY

(NOTE: There is a multitude of monographs, texts, and articles about adolescent development. The reader interested in general readings on adult and adolescent development is encouraged to consult the bibliography of the "Human Growth and Development" module, pp. 81-82 of this curriculum, for references to several such works. The works described below are more relevant to this module.)

Adelson, Joseph. "Adolescence and the Generalization Gap." *Psychology Today*, February 1979.

This issue has a major section on adolescence.

Adolescence. Roslyn Heights, N.Y.: Libra Publishers.

A journal devoted to discussions of all sorts of research on and work with adolescents - including residential and foster care. A useful tool.

Beckham, Cecilia Owen; Johnston, Lon; and Beckham, Ernest. "Sex Education for Children in a Residential Center." *Child Welfare* 57, no. 6 (June 1979).

A clear, concise discussion of the need for a sex education program in residential centers. The authors describe one such program, pointing out important preparatory and follow-up steps. A worthwhile discussion which child care workers can adapt to their own situations.

Fleetwood, Robert S., and Parish, Thomas S. "Relationship Between Moral Development Test Scores of Juvenile Delinquents and Their Inclusion in a Moral Dilemma Discussion Group." *Psychological Report* 39 (1976).

An example of the controlled application of Kohlberg's proposals regarding both moral development and the teaching of moral reasoning. This particular application is of significance because the subjects obviously resemble the resident population of many child caring agencies.

King, Charles. "The Ego and the Integration of Violence in Homicidal Youth." *Journal of Orthopsychiatry* 45, no. 1 (January 1975).

King describes several homicidal youths and finds that their most significant common characteristic is a lack of intellectual development. This lends support to Kohlberg's linking cognitive and moral development and underlines the need to treat the *whole* child, answering as many needs as possible.

Kohlberg, Lawrence. "Moral Education for a Society in Moral Transition." Educational Leadership, October 1975.

Although Kohlberg presents his theory in many places, this is one of the most readable. It includes an outline of the stages, a discussion of stage theory, and a description of the beginning of the author's experimental high school. For other Kohlberg articles, see the references to this module's resource paper, pp. 326-27.

Muson, Howard. "Moral Thinking: Can It Be Taught?" Psychology Today, February 1979.

Muson describes the theory of moral development proposed by Kohlberg, criticism of the theory, and interesting attempts to apply it. A good general introduction to this fascinating area of psychological research.

Newman, Barbara M., and Newman, Philip R. "Early Adolescence and Its Conflict: Group Identity Versus Alienation." Adolescence 11, no. 42, (summer 1976).

These authors propose to divide the traditional single stage of adolescence into two separate stages. They make an interesting case by stressing the various things adolescents must accomplish. The basis of this module's focus on the four tasks presented is to be found in this article.

HANDOUTS

SELF-ASSESSMENT: ADOLESCENT DEVELOPMENT

It will be helpful to you and your instructor to monitor any changes in your professional activities that occur after training. This instrument will help perform that task, so please answer carefully.

Use the appropriate boxes below to respond to the following items. Answer "yes" or "no" to items (a) and (b); choose the number on the scale that most closely represents your level of activity for (c), (d), and (e). Repeat at three months and six months after training.

a. I can identify the four major developmental tasks of adolescence, the behaviors associated with them, and how residential placement can help or hinder the accomplishment of those tasks.

b. I can define the six stages of moral development (Kohlberg's theory) and assess the stage someone is in.

c. I make it a point to know what developmental tasks each teenager with whom I work is dealing with.

d. I try to find as many constructive ways as I can to provide teens with the opportunity to work out their adolescent tasks.

e. I try to know what stage of moral development each teenager I work with is in and I make it a point to use appropriate strategies to promote growth in this area.

1	2	3	4	5	6	7	8	9	10
never		occasionally		sometimes			often		always

	a. Tasks, behavior	b. Six stages	c. Teen's tasks	d. Constructive ways	e. Promote growth
1. Before training					
2. Three months after training					
3. Six months after training					

Your goal in participating in training is to increase your professionalism. If you don't see any such increase resulting from training, try to determine why and share that information with your trainer.

SMALL GROUP TASK

For your assigned topics, list how attitudes about those topics affected you as a teen and how they affect teens today.

	When I Was a Teen	For Teens Today
1. Rules and Regulations		
2. Schooling		
3. Roles of Men and Women		
4. Authority		
5. Optimism for the Future		
6. Community and City Life		
7. Jobs		
8. Family Life		

TASKS OF ADOLESCENCE

1. PHYSICAL MATURATION: rapid spurts of growth, onset of sexual impulses, maturation of reproduction system.

   Problems

   a. Early maturation may cause adolescent to be considered emotionally mature when he/she is not. Leadership and other responsibilities are often forced on this adolescent.
   b. Late maturation may cause isolation, feelings of inadequacy.

2. HETEROSEXUAL AND PEER RELATIONSHIPS: development of social skills, clique memberships, sex role, romanticism and idealism, and a striving to conform to peer group norms, values.

   Problems

   a. Maturational lag between development in girls and boys may cause stress.
   b. Nonacceptance by a particular group can lead to alienation and depression.
   c. Parents often add stress by trying to dictate with whom adolescent associates.

3. INDEPENDENCE: adapting to adult role; seeking vocational choices and skills for independent living; developing own values, morals, and thinking process while challenging those of adults; beginning to see flaws in parents.

   Problems

   a. Although becoming more adult, adolescents still do not have many privileges of adults.
   b. Expected to make decisions, they are still immature.
   c. In striving for independence they may exhibit hostile and frantic behaviors.

4. IDENTITY: "Who am I?" and "Where do I belong?" Time of trying different roles, self-analysis and introspection, development of formal abstract thinking (ability to think about cause and effect), development of intellectualism, seeing self as different from peers.

   Problems

   a. Tendency to be egocentric - "The world is watching me."
   b. Refusal to accept any socially acceptable role can cause them to become alienated, depressed, delinquent, etc.

STAGES OF MORAL DEVELOPMENT*

I. Preconventional Level

At this level the child is responsive to cultural rules and labels of good and bad, right and wrong, but interprets these labels either in terms of the physical or the hedonistic consequences of action (punishment, reward, exchange of favors) or in terms of the physical power of those who enunciate the rules and labels. The level is divided into the following two stages:

Stage 1: The punishment and obedience orientation. The physical consequences of action determine its goodness or badness regardless of the human meaning or value of these consequences. Avoidance of punishment and unquestioning deference to power are valued in their own right, not in terms of respect for an underlying moral order supported by punishment and authority (the latter being stage 4).

Stage 2: The instrumental relativist orientation. Right action consists of that which instrumentally satisfies one's own needs and occasionally the needs of others. Human relations are viewed in terms like those of the marketplace. Elements of fairness, of reciprocity and equal sharing, are present, but they are always interpreted in a physical pragmatic way. Reciprocity is a matter of "you scratch my back and I'll scratch yours," not of loyalty, gratitude, or justice.

II. Conventional Level

At this level, maintaining the expectations of the individual's family, group, or nation is perceived as valuable in its own right, regardless of immediate and obvious consequences. The attitude is not only one of conformity to personal expectations and social order, but of loyalty to it, of actively maintaining, supporting, and justifying the order and of identifying with the persons or group involved in it. At this level, there are the following two stages:

Stage 3: The interpersonal concordance or "good boy-nice girl" orientation. Good behavior is that which pleases or helps others and is approved by them. There is much conformity to stereotypical images of what is majority or "natural" behavior. Behavior is frequently judged by intention - "he means well" becomes important for the first time. One earns approval by being "nice."

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* From Lawrence Kohlberg, "Moral Development and the Education of Adolescents," in Adolescents and the American High School, Richard F. Purnell, ed. (New York: Holt, Rinehart and Winston, 1970). Used by permission.

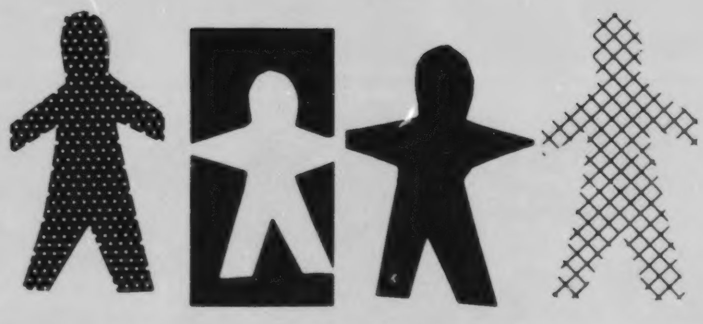
Stage 4: The "law and order" orientation. There is orientation toward authority, fixed rules, and the maintenance of the social order. Right behavior consists of doing one's duty, showing respect for authority, and maintaining the given social order for its own sake.

III. Post-Conventional, Autonomous, or Principled Level

At this level, there is a clear effort to define moral values and principles that have validity and application apart from the authority of the groups or persons holding these principles and apart from the individual's own identification with these groups. Again, this level has two stages:

Stage 5: The social contract legalistic orientation. This has generally utilitarian overtones. Right action tends to be defined in terms of general individual rights and in terms of standards that have been critically examined and agreed upon by the whole society. There is a clear awareness of the relativism of personal values and opinions and a corresponding emphasis upon procedural rules for reaching consensus. Aside from what is constitutionally and democratically agreed upon, the right is a matter of personal "values" and "opinion." The result is an emphasis upon the "legal point of view," but with an emphasis upon the possibility of changing law in terms of rational considerations of social utility (rather than freezing it in terms of stage 4, "law and order"). Outside the legal realm, free agreement and contract are the binding elements of obligation. This is the "official" morality of the American government and Constitution.

Stage 6: The universal ethical principle orientation. Right is defined by the decision of conscience in accord with self-chosen ethical principles appealing to logical comprehensiveness, universality, and consistency. These principles are abstract and ethical (the Golden Rule, the categorical imperative); they are not concrete moral rules like the Ten Commandments. At heart, these are universal principles of justice, of the reciprocity and equality of human rights, and of respect for the dignity of human beings as individual persons.



Child Care and Cultural Differences

by *Wayne Ouderkirk*

INTRODUCTION

The results of the Child Care Training Needs Assessment, conducted in 1977, indicated that "black workers rate 'minority group children and families' as desired training topics in far greater numbers than do white workers."* This fact was notable because 87 percent of the workers who responded to that study were white. At that time, it was felt that this concern of black workers needed to be met, since most, if not all, of those surveyed worked with minority group children.

This module is our response to that training need. Several points about it need to be noted. First, it does not attempt to give a systematic description of any minority culture. Project staff agreed that such an attempt would be both impracticable within our training structure and presumptuous, since at that time there was no minority group represented on the staff. Second, the module attempts to resolve the difference in the perceived training needs of black and white workers by forcing the workers to realize how much they have been influenced by their own cultures. Third, this self-awareness aspect is then linked to the discussion of working with minority group children.

Thus, the attempt here is to sensitize workers to their own culturally determined attitudes, as well as to the cultural identities and needs of the children in care.

BEHAVIORAL OBJECTIVES

After participating in this training session, workers will be able to

1. Identify at least two effects of culture on their personal or professional behavior.
2. Identify at least two kinds of culturally different behaviors of children in care that might be misinterpreted as socially unacceptable.
3. Explain clinicalism and paternalism and why they are to be avoided.
4. Identify at least two ways in which their agency does or could recognize and incorporate cultural differences into its residential program.

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* Mary Armstrong et al., Child Care Training Needs Assessment, School of Social Welfare, State University of New York at Albany, 1977, pp. 19-20.

BEHAVIORAL CHANGES

1. In verbal and written communications, participants will demonstrate awareness of cultural influences on their own and others' behavior.

2. Participants will seek out new ways to accommodate children's cultural differences within their own agency program.

RESOURCE PAPER: CHILD CARE AND CULTURAL DIFFERENCES

Culture is a subtle yet powerful influence. Though it is exhibited in behavior, personality, and values, it is so much a part of the individual that it is easily overlooked. Simply put, culture is the way of living of a group of people whose members "share a particular social, economic, and linguistic background."[1] Child care workers have a twofold purpose in becoming aware of the great influence of culture. First, they have been formed by their own cultures. The values and roles thus acquired can influence professional activities. Such an influence may or may not be beneficial, depending on the situation, the child, and the worker, so the worker must be able to perceive these influences in order to control them. The second reason for child care workers to attune themselves to cultural differences is that most, if not all of us, work with some minority group children. It is crucial in our work with them that we not interpret culturally different behaviors as pathological. The result would be totally antithetical to our professional goals of helping children achieve positive self-images.

These two purposes are related in many ways, since they both relate to the professional activity of the worker. So it will be assumed throughout that in speaking of cultural influences, we are referring to influences on both the worker and the child.

The influence of culture on behavior and personality can be illustrated in many ways. Focusing, for example, on the formative years, we can see the child as surrounded by a wealth of cultural practices; family structure, eating customs, and emotional expression are just a few such practices that depend on one's culture. These practices are learned by the growing child, sometimes without ever being explicitly taught. They later influence the grown person's actions. For example, males reared in a culture with a male dominated family structure are quite aware that the effects are difficult to overcome, even with an intellectual and emotional commitment to do so. Similarly, those reared in a culture that emphasizes cooperation find it difficult to become aggressively competitive. These rather simple examples illustrate the power of culture to shape reactions.

Most of us are familiar with the outward signs of culture and ethnic identity.[2] Our culture often influences our dress, holiday customs, language, moral codes, skin color, and many other observable features. However, it is a mistake to identify culture with such factors. The reason is that the outward trappings may or may not be present, while the more subtle and powerful personality factors always are. It is these personality factors that determine values and reactions and hence require the professional's attention. Put into a very general schema, one's culture determines how one sees the world, especially how one views human nature (whether or not the view is made explicit). In turn, this view of human nature determines one's view of oneself and how one perceives social situations. Within social situations how one relates to and/or wields authority and power are particularly significant to child care. Another equally relevant factor that culture shapes in social situations is how one gives or asks for help.

Although this schema is very broad and consequently vague, it nevertheless illustrates the far reaching effects of culture on any personality. Obviously, personality affects behavior. In this way, culture's effects reach into virtually every observable interaction. Laosa has given an instructive list of frequently misunderstood characteristics or behaviors of culturally different children.[3] These behaviors aptly illustrate how differing cultural backgrounds can give different meanings to similar behaviors. Since these behaviors are often found in workers' summaries, team meeting reports, and so on, they are mentioned here to illustrate the need for workers to exercise caution in their use.

1. Lack of response to conventional approaches. Perhaps an upset child forcefully rejects physical comforting from the worker, or another child, though physically fit, does not enter into the cottage's athletic program. The problem may not be the child's response, but rather the conventionality of approach. Some families discourage physical contact outside the immediate family and intimate friends; other groups emphasize cooperation rather than the competition of sports.

2. Socially unacceptable behaviors. A worker may find that a child, while being justly reprimanded, refuses to look at the worker. The worker reports that the child is defiant. Yet, most Hispanic children are taught to look away when reprimanded - as a sign of respect!

3. Inadequate communication skills. Bilingual children are often less fluent in English than in their native tongue; and black children often learn dialect before they learn "proper" English. Within their own culture these children communicate well. Labeling their skills as inadequate ignores one of their true strengths.

4. Nonpurposeful activity. The child's behavior may look nonpurposeful, but the worker doesn't know all the purposes there can be!

5. Low scores on standardized tests. Many professionals are aware of the cultural bias of many standardized tests, but caution is still required in interpreting scores where such tests are still used.

These are not the only misunderstood behaviors or characteristics of culturally different children, nor are the examples given the only ones that could be listed. The main point is that the worker's culture and culturally influenced training can narrow his or her perspective. It is important to keep that perspective broad. Gary Weaver characterizes the differences between the mainstream culture, often represented by the worker, and the non-mainstream culture, usually represented by the child, by calling the former "abstractive" culture and the latter "associative."[4] Weaver gives interesting and insightful descriptions of these two cultural streams. Moreover, another of his main points is of interest here: he makes the claim that the "melting pot" metaphor of cultural equality is a myth and that the various American identity movements - Indian, Black, Puerto Rican, for example - illustrate the determination of various cultures to reject what he calls the Anglo-Saxon cookie cutter. The melting pot has really signified the subjection of a variety of cultures to the dominant cultural pattern.

Weaver's claim can be interpreted as a plea for recognition of and support for cultural pluralism. Such a pluralism would recognize the differences of cultures and legitimacy of those differences. This is identical with Laosa's ideal of a "culturally democratic" environment in child care[5] and with Miller's hope for cultural pluralism as an official policy of the social welfare system and the country at large.[6]

Such approaches to the differences between cultures would obviate the mistakes made by both the racist and the liberal. The racist believes that cultures are different and those different from his are inferior. The liberal believes that people are not different and that no culture is inferior. Pluralism stresses the real differences that exist between cultures but agrees that differences do not imply superiority or inferiority.[7]

Two manifestations of the liberal attitude in the helping professions have been described by Miller.[8] Child care, like social work, must make every effort to avoid them if it is to achieve a culturally democratic environment. The first, paternalism, is familiar to many of us in contexts outside of child care. Within our profession, it can be seen in helping efforts that are predicated on assumptions of cultural underdevelopment. Such efforts ignore the child's own background and impose another set of assumptions on him. The child is made over into the worker's or the agency's image of what he should be. But the child has a culture, different and equal. Even if there were no other arguments in favor of cultural pluralism, the fact that a child's culture is a crucial aspect of his identity would compel us, as child care professionals, to provide as many links as possible between the child and the culture. Nothing less should be expected of the "therapeutic milieu," so widely touted as child care's powerful tool.

The other liberal attitude to be avoided, Miller calls clinicalism. This is the presumption of psychological damage to an individual because of attitudes toward the individual's culture. Obviously, this presumption blatantly ignores other cardinal tenets of child care: the recognition of individual differences and the effort to individualize treatment in a group context. To avoid clinicalism, child care must hold fast to those tenets and continue assessing strengths and weaknesses on an individual basis, while realizing that in some cases culture shock could be causing an individual child's problem in the unit.

The whole point, then, of creating a pluralistic environment in child care is to increase that environment's capacity to help children grow and deal with the problems that bring them into care. In this effort, culture becomes another child care tool. A story from our training program will illustrate the importance of this effort. In a small group activity for child care workers, one participant felt unable to join any of the small groups that were constituted by cultural or ethnic background. The groups were to describe their own cultural backgrounds in relation to such factors as male-female roles and relationships, crisis experience, and expression of emotion. The person in question completed the task as a group of one and labeled the culture described as "institutional." Raised in an institution, this child care worker had affinities with several ethnic groups but honestly felt unable to identify with any of them. She described herself as hampered in the development of a strong personal identity by this lack of cultural identity. Although efforts are being made to minimize the length of time a child is placed in residential care, this gives us cause to look closely at our child care programs.

Three final points must be made. First, in order to achieve even a semblance of cultural plurality, that subject must be covered in child care training and should include first-hand contact with the various cultures of the children in care. Second, many of our non-mainstream cultures, especially Hispanic, are characterized by extended families, including compadres ("companion parents") who may or may not be legally related to the child.[9] A culturally democratic agency will have to pay close attention to visiting policies as well as to the formation of treatment plans for such children.[10]

Finally, in working with teenagers, workers confront "youth culture." For younger workers this doesn't present a major problem. Still, at times the question must be asked whether a particular behavior, activity, clothing style, or what have you, is or is not acceptable. Here a child care worker faces the broader issues of dealing with a society in flux and what standards to uphold. There is no pat answer, but a general guideline can be offered: child care ought not deprive adolescents of the opportunity to be adolescents. At times, this may mean the alteration of rules or policies.

The goal of placement is, when all is said and done, the return of the child to the community as soon as possible. This will be achieved more readily if child care is attuned to all of the various cultural influences on both the child's and the worker's behavior. Cultural democracy must be added to our list of child care techniques.

References (see p. 352 for full listings)

1. Luis M. Laosa, "Child Care and the Culturally Different Child," p. 214.

2. Although culture and ethnicity are different concepts, they are discussed under one name here. For a brief discussion of the distinction between culture and ethnicity, see Marta Sotomayor, "Language, Culture, and Ethnicity in Developing Self-Concept," pp. 195-213.

3. Laosa, pp. 219-20.

4. Gary R. Weaver, "American-Identity Movements," pp. 377-80.

5. Laosa, p. 221.

6. Henry Miller, "Social Work in the Black Ghetto: The New Colonialism," Social Work 14 (July 1969), pp. 65-76.

7. Weaver, p. 377.

8. Miller.

9. Emelicia Mizio, "Impact of External Systems on the Puerto Rican Family," pp. 76-83.

10. See module on "Children, Families, and Child Care Workers," p. 145. In attempting to involve the Hispanic family in the child's plan, attention should be paid to the extended family in cases where it exists.

SESSION OUTLINE: CHILD CARE AND CULTURAL DIFFERENCES

Time:	3 hours, 15 minutes
Space:	A large room; break-out rooms for small groups are important in this session.
Equipment:	Easel pad, stand, markers
Handouts:	"Self-Assessment: Child Care and Cultural Differences," p. 354 "Cultural Influences on Behavior," p. 355

1. Introduction — 10-15 minutes

The trainer distributes the "Self-Assessment: Child Care and Cultural Differences" handout and asks participants to respond to the statements by filling in the "before training" boxes. The trainer explains the importance of participants' repeating their self-assessment at three months and six months after training, then returning the completed form with their comments to the trainer.

A brief but clear statement of the importance for child care work of sensitivity to cultural norms, values, and influences on behavior must be made at the outset. Another significant introductory point for this session is that no attempt is being made to provide workers with knowledge of minority cultures. The main point of the activities is to increase awareness of the differences that culture can make on personalities and to stimulate further investigation of cultural patterns by both workers and their agencies.

2. Cultural and Ethnic Groups — 45-60 minutes

The purpose of this activity is to make participants aware of how their own cultures have influenced them. The trainer breaks down the large training group into smaller working units by cultural or ethnic backgrounds. In our experience, we have had many different groups: Irish-Catholic, black, Italian, southern Mediterranean, WASP, Jewish, Puerto Rican, etc. The possibilities are as many as there are national or ethnic groups. On some occasions, there might be no group with which an individual identifies; for other persons, there might be more than one such group. The main criterion is which group represents the culture that most influenced the individual.

Some participants have protested at this point that most of us are products of the melting pot and share the same culture. Since part of the purpose of this session is to show that the melting pot image is a myth, we have asked such protestors to participate so that they can test their claim by seeing whether the various small groups come up with significant differences. That brings us to the task for the

315

groups. The sample handout "Cultural Influences on Behavior" includes values and beliefs that the groups are to consider in describing ways in which their own cultural/ethnic background has influenced them. Each group is given an easel-pad sheet and magic marker to record its findings and is asked to be ready to report back to the large group.

3. Group Report 60 minutes

Each small group posts its easel-pad sheet and a spokesperson clarifies the report to the large group. We have found that the experience provided by the previous activity can be a moving one for many participants, and adequate time must be given them to express their findings and reactions to it.

SHORT BREAK 15 minutes

4. Lecture-Discussion 20 minutes

The trainer, referring to the major differences among the cultures of the participants, again notes the importance of a sensitivity to these differences in child care work. The relation of culture to such issues as individual identity, personality factors, and nonverbal behaviors is discussed. Examples are given of significantly different behaviors that could be mistaken for "socially unacceptable" ones by an insensitive eye. Participants can be asked for additional examples. The adverse effects of racism as seen in paternalistic and clinicalistic attitudes are underlined; a case is made that the therapeutic milieu must be a culturally democratic environment.

5. Small Group Activity 20 minutes

a. Participants are divided into work groups. They should be grouped in such a way that workers with similar groups of children or similar agencies or units are together, if possible. The trainer can have these groups fixed ahead of time. Their tasks are (1) to list those things they or their agency or unit already do to recognize cultural differences among the children; and (2) to find some other thing they could initiate in their agency or unit to make it more responsive to cultural differences.

b. Each group then shares its lists with the large group.

6. Conclusion 10 minutes

Trainer briefly summarizes the session and asks participants to write "I learned" statements regarding their insights, etc., from the session. Volunteers can share their statements with the group, and the session is complete.

ANNOTATED BIBLIOGRAPHY

Cooper, Shirley. "A Look at the Effect of Racism on Clinical Work." Social Casework 54 (February 1973).

A good look at problems such as the obscuring of therapeutic issues by ethnic issues and white guilt as an interference in therapeutic relationships. Written from a social work perspective, but child care workers can easily translate the issues to the context of residential care.

Ghali, Sonia. "Culture Sensitivity and the Puerto Rican Client." Social Casework 58 (October 1977), pp. 459-468.

A good discussion of the need for sensitivity to cultural factors in a helping situation.

Laosa, Luis M. "Child Care and the Culturally Different Child." Child Care Quarterly 3 (winter 1974), pp. 214-24.

Probably the best discussion of these issues for child care workers. Highly recommended. Laosa discusses the concept of culture, culture differences, and culturally different behaviors, and makes the case for the culturally democratic milieu.

Mizio, Emelicia. "Impact of External Systems on the Puerto Rican Family." Social Casework 55 (February 1974), pp. 76-83.

The extended family system of Puerto Ricans and the impact of the confrontation with American urban society are examined here.

Sotomayor, Marta. "Language, Culture, and Ethnicity in Developing Self-Concept." Social Casework 58 (April 1977), pp. 195-213.

The distinction and relationship between culture and ethnicity are clarified. The effects of the three factors in the article title are examined.

Weaver, Gary R. "American Identity Movements: A Cross-Cultural Confrontation." Intellect Magazine, March 1975, pp. 377-380.

An excellent and succinct comparison of the strengths and weaknesses of abstractive and associative cultures is contained in this article. Also to be found here are Weaver's claim that the melting pot is a myth and a cogent appeal for cultural pluralism.

HANDOUTS

SELF-ASSESSMENT: CHILD CARE AND CULTURAL DIFFERENCES

By filling out this form, you can find out whether the training in which you participate has any useful effect. You can also provide important evaluative data for your trainer's use. So take the time to use this instrument wisely.

Choose the number on the scale that most closely represents your level of activity for each of the four following items. Write that number in the proper box. Repeat at three and six months after training.

a. I try to be aware of how my own cultural background bears on my professional life.

b. I make it a point to find out about each child's cultural background and values.

c. I try to determine whether any unusual actions exhibited by the children are simply "culturally different" rather than "abnormal."

d. I make efforts to encourage and stimulate the children's expression of their various cultural heritages (i.e., strive for cultural democracy in the unit).

1	2	3	4	5	6	7	8	9	10
never		occasionally		sometimes			often		always

	a. My culture	b. Children's culture	c. Culturally different	d. Cultural democracy
1. Before training				
2. Three months after training				
3. Six months after training				

The purpose of this form is to determine whether an increase in these behaviors takes place following training. If it does not, try to find out why so future training can be improved.

CULTURAL INFLUENCES ON BEHAVIOR

During this session we will focus on the cultural/ethnic background of individuals' behavior. The task for your group is to describe ways in which your own cultural/ethnic background has influenced you. Take into consideration religious factors, ethnic values, family structure (especially child-rearing practices), etc.

In your discussion focus on the effects those factors have had on your behavior, values, and beliefs in regard to:

male/female roles and relationships

why a person is valued

adult/child roles and relationships

traditions/customs

expression of feelings

ways of coping with stress or a crisis

achievement

Choose someone from your group to report back to the general session.

Crisis Prevention/Intervention

by Anne Stea

INTRODUCTION

Children placed in residential settings rather than foster care or day treatment often act out most severely and thus require the greatest control from those who have the responsibility of caring for them. Dealing with one acting out child can be an awesome experience, but trying to provide controls and safety for a whole group can definitely be overwhelming to even the most experienced child care worker.

Any upset in the relatively stable state of a child in placement may result in a building of tension followed by a burst of angry and terrifying words or actions. An adult who must intervene at this point of crisis is bombarded by the intensity of both the child's feelings and his or her own. Because of the emotional charge that is present in any acting out situation, crisis intervention in child care becomes an art that calls upon every bit of skill, strength, and knowledge that a worker can conjure. Thus it becomes crucial to examine this highly demanding intervention skill of child care workers.

The purpose of this module is threefold. First, it is to help the worker to identify the feelings that are common to both child and worker in a crisis situation. Second, it is to develop a coping strategy for crisis management. Finally, it is to identify specific techniques that can be used to prevent a rise in tension in a child's behavior from culminating in a crisis for both child and worker.

BEHAVIORAL OBJECTIVES

At the end of this session, the worker will be able to

1. Identify at least three feelings or reactions that are common to both worker and child in a crisis situation.
2. List and explain the relevance of the following five components in formulating a coping strategy for crisis management: self-awareness, assessment, timing, intervention techniques, and follow-through.
3. Describe at least three specific intervention techniques that could be used in a given crisis situation.

BEHAVIORAL CHANGES

1. The worker will use several intervention techniques to stop acting out behaviors before they reach a level that would demand physical restraint. This will be evidenced by a reduction in the number of restraint situations a worker becomes involved in.

2. The worker will view a crisis as an opportunity for treatment rather than as an overwhelming and fearful situation. This will be evidenced in log and crisis reports and in team conference discussion.

RESOURCE PAPER: THE DYNAMICS AND TECHNIQUES OF CRISIS INTERVENTION

Recently, when I returned for a short stint at "on-the-line" child care work, the trickiness of handling a crisis came back all too clearly. During my years away from direct child care, I had often pondered the "art" of crisis intervention and wondered what it was that made all acting-out behavior suddenly seem like a crisis.

I was considering that question in the kitchen of the group home when I heard an argument erupt over who should sit in the recliner chair in the TV room next door. One would think that this certainly was an easy enough situation to handle - after all, it was just some loud voices, no physical fighting or loud name calling. But there it was - an immediate knot in my stomach, a momentary thought of walking out the back door until it was over.

Then I heard my co-worker intervening. The knot grew tighter in my stomach as I heard the tension in his voice. The noise level rose. The argument turned to name-calling, and my co-worker was called names for intervening. That did it! I snapped. I ran into the TV room screaming like a wild woman, bombarding the two boys with all of my feelings about swearing, name calling, arguing, and so on, and ended by telling them to go sit on a bench "out of my sight!"

One boy went out, but the other, who had received the brunt of my wrath, began slamming things about and threatening to destroy property. My co-worker had to physically restrain him. We then conducted life-space interviews with both boys. In an hour, all was calm.

However, my handling of the situation left some things to be desired, and I knew it. Basically, for several days one of the boys had been testing my limits and I had let him control me. The resentment had grown within me, so that when I finally took control, I overreacted to compensate for my previous lack of control. Also, I wasn't sure - didn't trust - whether my co-worker was going to resolve the situation and maintain control of the boys.

Later that night, while writing up the incident, my co-worker and I were discussing what had happened and discovered that a word kept coming up - control. No one wants to lose control of himself or herself. Also, everyone wants to feel that someone else will be able to take over if he or she does lose control. This is the crux of the problem for the child care worker, the parent, the teacher, or any adult who is acting as an authority-control figure. We are the ones who must always have control and provide control for others. Who can provide it for us if and when we should lose even some control? What do we feel when there is no other adult present? Or if adults are there, do they expect us to be the control factor? An almost unconscious thought, left over from childhood, always lurks just beneath the surface, reminding us that it was so much easier when there was someone who would and could take over if we were not up to it.

Children look to us for security in the form of control. We child care workers pride ourselves most in being able to provide control, and yet we often secretly resent this expected task. It is fine to be in control of ourselves, but "Please, don't make me do it for others!" This is the feeling that most often causes that knot in the stomach, the wish to avoid a confrontation, the hope that the children will gain control before one has to intervene. It is also probably the most common reason why many child care workers fall short in crisis intervention. The tensions that we feel, knowing that it is up to us - that there may very well be chaos if we "lose out" - are so often what cause us to make poor assessments of the situation, overlook cues of oncoming acting out, intervene at the wrong time, use inappropriate intervention techniques, and forget to follow through and utilize the chance for therapy that is always available in the resolution of a crisis.

These feelings - of helplessness, loss of control, tension - and the importance of timing all go into the formulation of the definition of a crisis. It is an upset in a steady state that involves a general feeling of loss of control, a rise in tension that reaches a peak as some sort of acting-out behavior, and is time limited.

The two key phrases in this definition of a crisis are "loss of control" and "time limited." The child care worker who is called upon to intervene must know that his or her primary task is to restore control to the child. Secondly, a worker must remember that a crisis rarely erupts without warning. Usually there is a building of tension before the acting out. A crisis situation is time limited and has a beginning, a middle, and an end.

The remainder of this paper will look more closely at the various intervention functions of the child care worker in each of the three stages of a crisis.

The Beginning Stage: Picking up early cues and attempts at preventive intervention

(At this point the reader should note that the terms crisis and acting out will be used interchangeably throughout the rest of this paper. It should also be noted that the term acting out does not just refer to verbal or physical aggression, but may also include sexual behavior, stealing, extreme depression, and other problem behaviors.)

The beginning of a crisis is usually evidenced by some change in a child's or group's normal behavior. For example, a child may become abnormally quiet after a phone call home; or a child who usually has little trouble with bedtime routine suddenly begins to resist going to bed. A child care worker should be wary of any such behavioral change in a child and should immediately ask whether this behavior has ever been displayed before by the child. If so, what pattern surrounded the behavior before - i.e., did it lead to another specific behavior? If either a child or a worker is new it will take a while for the worker to know where certain behavior may lead. Each child has behavior cues that can be picked up once they are known. Most disturbed children, as well as healthier ones, develop coping patterns for dealing with inner turmoil and loss of control. Thus it becomes essential for a child care worker to learn which issues, times, places, other children, and so forth, trigger tension and acting out in each child, as well as how the child usually handles such situations. It may be a good idea to keep a special log of each child's acting-out behavior cues; e.g., "When Jimmy plays competitive games right after school, he inevitably ends up in arguments and fights."

When a worker first spots tense, hyper, or other unusual behavior by a child, he or she needs to recollect as much information as possible about the child, such as where this child is developmentally, what are the basic treatment goals, where he or she is in the process of dealing with separation from home and family, and how this behavior compares with patterns previously established.

Along with an initial assessment of what the child's behavior may signify, workers should also be aware of what feelings and reactions certain types of child behavior trigger in themselves. For example, how they feel about swearing, sexual intimidation, suicide threats, physical aggression, or whatever else is present or is likely to arise. It is so important for workers to know their own temper testing areas as well as the child's, so that they can practice responding to certain behaviors that might otherwise provoke overreactions.

If child care workers have taken the time to become aware of their own fuses and have also worked at knowing each of the children thoroughly through daily log keeping, specific goal planning, and daily individual interactions, they will be able to assess the potential for a crisis situation very quickly by observing only one or two seemingly small behavioral cues.

This quick assessment skill will enable workers to decide whether or not intervention is necessary and if so, when and how to intervene. Workers who are skilled at such assessments will know that some children.are long-term rumblers while others cut this stage short, leaving little time for adults to plan their intervention. They will also know that some children are noisy, others less noticeable. Once aware of these patterns, workers can often help a child talk about the behavior, and that may be all that is required to enable the child to maintain control. Such careful timing, by making preventive intervention effective, may avert a real crisis. However, the amount of time between initial tension and its culmination in a crisis varies from child to child, and the worker may not have enough time to intervene before a child has lost control. When this is the case, the worker will find himself or herself in the middle stage of a crisis.

The Middle Stage: Physical and/or verbal intervention

If talking with a child during the early stage of a crisis has failed and the child continues to escalate toward loss of control, the child care worker will have to intervene actively and stop the behavior. There may be instances of acting out that a worker will feel do not call for intervention, such as silly loud behavior that may be used by a child for the sole purpose of gaining adult attention. In such a situation the child care team may have decided to ignore the behavior.[2] However, most child care workers know instinctively when an acting-out behavior is at crisis level. Even when the acting out is not in the form of extreme physical or verbal aggression, there are situations that call for prompt worker intervention. Intervention may be needed

- to avoid overexcitement, anxiety, or guilt, e.g., a child found involved in homosexual acts
- to stop what would be a "contagious" behavior for the rest of the group, e.g., a child who is giggling during a movie
- to protect an ongoing activity or program, e.g., a child who is not following the rules of the game
- to mark an issue, e.g., a child who consistently cheats at card games
- to avoid conflict with the "outside world," e.g., a child wandering off to fish on a private citizen's dock[3]

It is the physical and/or verbally aggressive acting-out situation that is most apt to reach the middle stage of crisis -- the stage in which the child totally loses control. This is the crisis situation that is probably the most difficult for all workers to deal with for a variety of reasons, but especially because they must now take over control of the child. The reader will recall the dynamics of this forced control situation as discussed earlier in this paper.

Sometimes a loud direct verbal command to "STOP" the behavior will be a sufficient shock to stop the child. This usually depends on the relationship between the worker and child and how much control the child has actually lost. If the immediate behavior can be stopped by verbal intervention, the worker should then take the child to an isolated area and proceed with a life-space interview to help the child regain total control and point out alternate ways for the child to deal with similar feelings or situations in the future.

If verbal intervention does not work and the child is in danger of hurting himself or herself, another child, or a staff member, or is destroying property, then physical intervention will be required. Several holds that are safe for physically restraining a child can be learned by almost any worker. The type of hold that is necessary and safe will vary with the size and sex of the child, the strength of the worker, and the degree of loss of control.*

Some holds or maneuvers should not be used when physically intervening with a child. To avoid causing injury to the joints or the spinal cord,

- do not pull arms behind the back
- do not jerk the child by pulling on any joints, i.e., wrists, elbows, etc.
- do not grab the child at the back of the neck or shake the child

There are several general points to remember when physically restraining a child who has lost control:

1. While moving in and holding the child, give directions loudly and clearly. Let the child know that you are taking control.

2. Do not try to deal logically with a child who is out of control. Don't argue but do show genuine feelings. (If you are angry, say so.) Indicate to the child that this will not be an unlimited episode, and that you are in control.

3. Always make the assumption that the child wants to regain control; tell the child he or she can and that when he or she does you will back off. Control should be given back to the child gradually, limb by limb if necessary, so that the worker can easily regain control if the worker finds he or she has let up too soon.

4. When physical restraint is necessary, try to remove the child from the group or the group from the child, as an audience will only prolong the amount of time that it takes the child to regain control because the child will feel that he or she must save face.

The Final Stage: Resolution or follow-through

Once the worker has been able to give control back to the child, he or she should not assume that the crisis is over. When a child has just been through a peak in tension, losing control and being controlled by an adult, the child will often go into a withdrawn phase.

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* A detailed verbal and pictorial description of acceptable holds for physical restraint is given in "The Therapeutic Management of Acute Physical Aggression in a Residential Treatment Center." This article was written by Dale Crandall and Paul Adams of the House of Good Shepherd in Utica, New York, and must be obtained from that residential center. Parsons Child and Family Center, Albany, New York, has also done extensive work in perfecting safe holds for physical restraint and has such information available.

At this point the child has basically regained control but is tired and is suffering from the psychological defeat of having been controlled.

The worker should respect this withdrawal by just sitting with the child for a while as a provision of security but no longer as a controlling intervener. When the child seems able to talk - this will vary greatly, from a few minutes to hours - the worker should use the opportunity to conduct a life-space interview about the incident. That is, he or she should first hear the child's view of what happened, then give his or her view of the incident, and help the child isolate cues and signals for future preventive intervention. The worker should either suggest or get the child to suggest other more effective ways of dealing with similar feelings in the future. Perhaps they might at this time set a specific goal together. If there are to be consequences for the child's behavior, these should be discussed now with the child.

Finally, the worker should bring the child back into the program by having the child clean up any mess he or she may have made or start on a job that he or she may have agreed upon as a consequence.

Above all, the child care worker should never end a crisis intervention without pointing out alternative ways for the child to handle such situations in the future. The worker should also give the child some hope by setting a short-term goal that the worker feels quite certain the child will be able to attain, thereby proving that he or she can behave appropriately and maintain control of himself or herself.

In summary, crisis intervention calls upon every skill and strength that a child care worker has. The more practiced a worker becomes at picking up early cues and signals of mounting tension, the more knowledge he or she gains about each child's patterns and ability to deal with developmental and psychological issues, the more acute his or her sense of timing as to when to intervene, the more effective he or she will be at preventive intervention and the less often he or she will be forced into taking total control of a child. A simple nod of the head or a hand on a shoulder at the right time is often enough to interrupt mounting tension in a child. But when physical intervention is required, it will help if the worker has practiced holds and is comfortable with his or her ability to stop the child's behavior. It will also help if the worker believes and remembers that the child does not really want to be out of control.

Crisis intervention is indeed an intricate skill, but done effectively it can result in some of the most effective long lasting treatment that a child will receive. As Haim Ginnot has said of the role of a teacher, I also say about a child care worker:

> It is my personal approach that creates the climate. It is my daily mood that makes the weather. As a teacher I possess tremendous power to make a child's life miserable or joyous. I can be a tool of torture or an instrument of inspiration. I can

humiliate or humor, hurt or heal. In all situations it is my response that decides whether a crisis will be escalated or de-escalated and a child humanized or de-humanized.[5]

References

1. Lydia Rapoport, "The State of Crisis: Some Theoretical Considerations," Crisis Intervention: Selected Readings, Howard J. Parad, ed. (New York: Family Service Association of America, 1955), pp. 22-31.

2. Fritz Redl and David Wineman, Controls from Within (Glencoe, Ill.: The Free Press, 1952). Planned ignoring is one of seventeen intervention strategies described by Redl and Wineman. The techniques offer various ways of intervening either in a potential crisis or one that is already well into the loss of control stage. (The handout "Techniques for Crisis Intervention," p. 385, summarizes these techniques.)

3. David Wineman, "Control - Discipline and Punishment," Proceedings of the 1963 Annual Child Care Seminar (Madison, Wis.: Department of Social Work, University of Wisconsin, 1963).

4. For a discussion of the life-space interview, see p. 229 of this manual.

5. Haim Ginnot, Teacher and Child: A Book for Parents and Teachers (New York: Macmillan, 1972), Chapter 4.

SESSION OUTLINE: CRISIS PREVENTION/INTERVENTION

Time: 2 hours, 15 minutes

Space: Room for large group and for role playing. Also, several break out areas for small group discussions.

Equipment: Easel pad, stand, and markers; or blackboard and chalk; or overhead projector and screen

Materials:
"What Is a Crisis?" p. 376
"Fantasy Trip," p. 377
"Three Stages of a Crisis," p. 376
"Trainer's Discussion Guide for Role Plays," p. 379
Handouts:
  "Self-Assessment: Crisis Prevention/Intervention," p. 380
  "Child Care Functions in a Crisis," p. 381
  "Three Crises: Role Plays," p. 383
  "Techniques for Crisis Intervention," p. 385

1. Introduction 10 minutes

The trainer passes out the "Self-Assessment: Crisis Prevention/Intervention" handout and asks participants to rate their performance of the activities indicated by writing their responses in the "before training" boxes. The trainer explains the importance of participants' repeating their self-assessments at three months and six months after training. After doing the last assessment, they are to return the completed form with their comments to the trainer.

The trainer notes that the terms crisis and acting out may be used synonymously in this session. He or she outlines the session and states its objectives.

2. Defining Crisis 10 minutes

The trainer asks participants how they would define the term crisis. They can brainstorm this question in small groups; when they report their ideas, the trainer writes their responses on a flip chart or blackboard. Then the trainer summarizes by relating the responses to the definition in "What Is a Crisis?" This can be recorded on a blackboard, flip chart, or overhead transparency.

3. Fantasy Trip and Discussion 15 minutes

At this point the trainer should introduce the purpose of the fantasy trip - to help each participant remember and experience some of the feelings that are inherent in any crisis situation that calls for the child care worker's intervention. The participants are instructed to sit back, relax, close their eyes, and so on. The trainer may wish to lower the lights in order to set a more intimate and relaxing atmosphere. It is the trainer's job here - as always - to create a safe environment for participants to enter into the activity.

The trainer reads the fantasy slowly to give the participants time to get into the feeling of the incident described. At the end of the fantasy, the trainer quickly brings the participants back to the discussion by asking, "What are your feelings right now?" The trainer processes some responses, then continues with the discussion questions that follow the fantasy.

In summarizing this portion of the session, the trainer should emphasize the similarities in the feelings of both child and worker during a crisis, i.e., fear, anger, helplessness, loss of control, powerlessness, etc. Because of the extreme tension, both physical and psychological, and the irrational thinking that may be involved in a crisis situation, it becomes extremely important for the child care worker to prepare himself for intervention by recognizing that a crisis with a child usually builds to a climax - in other words, that crises involve stages and the worker has important functions during each stage.

4. Mini-Lecture: Child Care Functions in a Crisis 10-15 minutes

Before presenting this mini-lecture, based on information presented in the resource paper, the trainer should distribute the handout entitled "Child Care Functions in a Crisis." He may also wish to use a blackboard, flip chart, or overhead of the "Three Stages of a Crisis," as a means of organizing the lecture and emphasizing the learning points visually.

In order to involve the participants more in the lecture, the trainer may wish to ask for examples of appropriate child care interventions for each of the three stages presented in the lecture. (Always remember to ask if there are any questions at the end of any lecture presentation.)

5. Role Plays (two or three, time permitting) 50 minutes

Preparatory Note: Role playing can be threatening for some participants. Depending on the mood or comfort level of the group, the trainer may need to provide a warm-up exercise. For example: The trainer directs the participants to form pairs. Each pair is to role play a child care supervisor conducting a job interview with a child care worker who has special skills in crisis intervention. After the role play goes on for five minutes, the pairs are given five minutes to discuss how they felt in their roles. The trainer then adds another role play safety factor by reminding participants that role plays are scripted and are not all intended to portray a totally effective and therapeutic worker.

The trainer will either select participants or have them volunteer to play the roles. Copies of the "Three Crises: Role Plays" are distributed, and for each role play, "actors" are given an area where they can convene for about five minutes to organize their presentation. For the role play situation, the trainer may wish to offer the participants the option of presenting an incident from their own experience. However, this technique is a more powerful one and requires that the trainer provide safety for the participants who share their experience with fellow workers.

The participants who are not involved in the role plays should be instructed to observe each role play with the following child care functions in mind: initial assessment of the situation, timing, taking control, giving back control, and follow-through. For each role play, all observing participants should be instructed to write down two questions, comments, or criticisms of the child care intervention in each situation.

It is important for the trainer to point out before role plays are presented that the role plays are scripted in such a way that they do not necessarily present effective child care techniques, and thus the workers playing the roles are not necessarily intervening the way they normally would, i.e., criticisms are directed toward the role not the actor!

The trainer should also instruct the participants that he or she will cut the role play off when he or she feels the learning points for each situation have been made. Participants should try to complete the role play incident in five minutes or less.

Following the presentation of each role play, the trainer leads a discussion of the effectiveness of the child care intervention, based on the questions, comments, and criticisms of the participant-observers and on the outline of the child care roles in "Three Stages of a Crisis." The "Trainer's Discussion Guide for Role Plays" will also be helpful in posing questions. (A special note to the trainer: The role plays have been designed to represent three different levels of effectiveness by the worker, from least effective in "First Crisis" to most effective in "Third Crisis.")

The trainer should summarize this portion of the session by reiterating the importance of the five child care functions in the stages of crisis intervention:

Assessment
Timing
Taking control
Giving control back
Follow-through

383

The trainer should emphasize that with careful work during the initial stage of a crisis, i.e., careful assessment, picking up early cues, appropriate timing, etc., often a real crisis or total loss of control by the child can be prevented. The trainer should also note that children go through the initial tension-building stage of a crisis at many different rates, and thus there are situations in which the worker has little or no time for preventive intervention and must resort to strong verbal commands and/or physical restraint. In either case, the more aware the worker is of the many different intervention techniques available and the more practiced he or she is in using each of the techniques (including physical restraint), the more comfortable and effective he or she will be in resolving any crisis with a child or group of children.

The trainer leads into the final segment of the session by stating that the group will now spend some time discussing the appropriate use of the different intervention techniques.

6. Specific Intervention Techniques

a. Small Group Discussion — 20 minutes

At this point the trainer distributes the handout entitled "Techniques for Crisis Intervention," which includes seventeen techniques described by Redl.

The trainer then divides the group into small groups of five or six. It may be wise to divide the groups according to the age, sex, and type of children with whom they work, putting similar workers in the same group. Each group takes two of Redl's intervention techniques and discusses for twenty minutes which technique would be most effective in particular situations and with particular children.

b. Process — 15 minutes

When the large group reconvenes, the trainer asks the small groups to present one of their assigned techniques and their list of incidents with which this technique might be effective. At the end of each small group's presentation, the trainer elicits any additional suggestions, examples, etc., from the whole group. Be sure each group has the opportunity to present one of its techniques; if time permits, the remaining techniques can be presented.

(For this whole section, the trainer may wish to emphasize skill building in using physical restraint. If so, he should obtain the help of child care personnel who have expertise in this skill and can demonstrate appropriate and safe holds to use when physically restraining a child. If this skill is demonstrated, participants should also be given ample time to practice the holds on each other, with the supervision of the child care expert. If this is to be part of the training session, it would be a good idea to let participants know in advance so that they can dress appropriately.)

7. Summary 5 minutes

The trainer should summarize the session by restating that a worker must recognize the stages of a crisis and equip himself or herself to use preventive intervention by

- learning as much as possible, as soon as possible, about each child's way of handling crises
- being aware of his or her own sensitive points and reactions to certain types of behavior and feelings about taking total control
- timing interventions carefully, based on knowledge of the amount of time it takes each child to escalate to a point of loss of control and of the early signals that each child gives as tension builds

When and if the child does lose complete control, the worker must intervene by

- immediately taking complete control (probably physically) and letting the child know that he or she (the worker) is in control and that the episode will be time limited because he or she will give control back to the child as soon as the child is ready
- giving control back to the child slowly
- following through on the treatment aspects of the crisis by doing a life-space interview in which the worker helps the child to see his or her own signals of trouble and helps the child to learn alternate ways of dealing with similar feelings in the future

Finally, the trainer may state that crisis intervention in child care is an art that calls upon every bit of skill, strength, and knowledge about a child that we can possibly obtain. By increasing our theoretical knowledge and practical skills in child care, we will decrease the number of crisis intervention situations that go unresolved and, therefore, are not used as the potential treatment tools that they are.

ANNOTATED BIBLIOGRAPHY

Crandall, Dale, and Adams, Paul F. "The Therapeutic Management of Acute Physical Aggression in a Residential Treatment Center." Utica, N.Y.: The House of Good Shepherd, 1975.

This article, written by child care workers, provides a discussion of alternatives to physical intervention as well as an in-depth verbal and pictorial description of safe, appropriate holds to use when physically restraining a child who has lost control. The physical intervention technique is described as involving six stages of involvement by the child care worker: (1) requesting, (2) directing, (3) holding, (4) letting go, (5) recuperation, and (6) return. The child care role for each stage is thoroughly discussed and demonstrated.

Drisko, James W. "Memo to Institution Staff: Physical Involvement with Children - A Therapeutic Intervention." *Child Welfare* 55, no. 7 (July/August 1976), pp. 469-77.

A good brief discussion of physical intervention, pointing to all the relevant issues from worker self-awareness to situations warranting restraint to legal issues.

Trieschman, Albert E. "Temper, Temper, Temper," *The New York Times Magazine*, April 12, 1970. This same information is available in Trieschman's *The Other 23 Hours* (Chicago: Aldine Publishing Co., 1969).

In this article Trieschman presents a description and discussion of the stages of a temper tantrum. Although *The New York Times Magazine* presentation of this concept is geared to parents, Trieschman's same concept is also included in his book written specifically for child care workers, entitled *The Other 23 Hours*. The temper tantrum is described as having six stages: (1) rumbling and grumbling, (2) help, help, (3) either/or, (4) no, no, (5) leave me alone, and (6) hangover. Trieschman describes the dynamics of what is happening to the child at each stage as the tension builds toward a crisis of acting-out behavior. He also includes appropriate steps to be taken by the parent, or other responsible adult, at each stage of the tantrum. The article is very readable and helpful and the illustrations that accompany *The New York Times*' version are superb!

INSTRUCTIONAL MATERIALS AND HANDOUTS

WHAT IS A CRISIS?

CRISIS - an upset in a steady state that

A. Involves a general feeling of helplessness or loss of control

B. Is time-limited

C. Usually involves a rise in tension which reaches a peak

D. Has a beginning, a middle, and an end (Trieschman's analysis of a temper tantrum)

E. Results in some form of acting out (i.e., verbal, physical, sexual, or more internal depressed and suicidal behavior)

THREE STAGES OF A CRISIS

I. BEGINNING PHASE

  A. Assessment

  B. Timing

II. MIDDLE PHASE

  A. Taking control

  B. Giving control back to the child

III. FINAL PHASE

  A. Follow-through and resolution

FANTASY TRIP

Relax, close your eyes....

I am going to take you back to your first week as a child care worker. It's your third day of work. You have just made it through two relatively relaxed days with your group of kids and that unknown person with whom you are working. You're feeling pretty good about yourself because so far this job is easier than you thought and you even have all of the kids' names memorized.

You walk in at 7 a.m. and the night worker tells you that your co-worker will be an hour late. You feel a bit uneasy but, after all, you do know the morning routine, so you tell the night worker he can leave. You begin to check and see if everyone is up and getting ready to do the morning house chores. You find two kids still in bed and tell them "up and at 'em guys!" They grumble and don't move too quickly, which irritates you a bit. After all, you had to get up at 6. You tell them they have five minutes to be up and dressed and proceed down the hallway to see how chores are going in the living area. Most of the group seem to be getting at their jobs so you walk into the office and pour some coffee. You look at your watch and realize that the two slow risers have only a minute left on your warning so you walk back down the hallway really hoping that they're up. But neither one has moved. You remind the first one that he knows the routine better than you and knows he is supposed to be up. He says that your co-worker lets him stay in bed longer because he's really fast once he's up! You wonder about that and decide that the boy should still get up now and that you're you, not your co-worker, and since he's not around the boy will have to go by your rules. The boy mutters a few choice profanities but gets up. You see that his late rising friend is also dragging himself out of bed.

You go about the rest of the morning routine. Ten minutes before breakfast one of the slow risers still hasn't begun his job and the other's jobs seem to have been poorly done. You're beginning to wonder how you're going to get everything done by school time, just as you hear some loud swearing at the end of the hallway. You run around the corner to find two boys circling each other with fists clenched. All of the other kids rush to the hallway...

Process

What are your feelings right now?

What were they when the two kids didn't get up the first time you told them to?

What might you do now?

How do you think the two boys who are about to fight are feeling?

In what ways are their feelings similar to yours?

TRAINER'S DISCUSSION GUIDE FOR ROLE PLAYS

1. What is the real issue here? (That is, what is the child's problem, where is he or she developmentally and in terms of dealing with separation and loss issues, and what are his or her feelings?)

2. What do you think this worker is feeling?

3. Did the worker intervene too soon or not soon enough?

4. Are there any other techniques that the worker might have used to prevent a crisis from occurring?

5. Did the worker take control when necessary?

6. Was the worker able to give the control back to the child?

7. Was the crisis resolved, leaving the child in control of himself or herself and with some ideas about how to prevent the same situation in the future?

SELF-ASSESSMENT: CRISIS PREVENTION/INTERVENTION

By using this form, you can not only monitor your learning but also provide valuable data for your trainer's use in improving future programs. So please be as accurate as possible in your answers.

Rate your performance of each of the following three items. In the appropriate box below write the number on the scale that most closely represents your level of activity for each item. Repeat this process at three months and again at six months following training.

a. I make a conscious effort to utilize all five child care functions in crisis management with the children with whom I work.

b. I make a conscious effort to assess each child involved in a potential crisis so I can use that awareness in either preventing or channeling the crisis.

c. I make a deliberate effort to be aware of and to react appropriately to my own feelings and reactions to various components of crises - shouting, swearing, physical contact, etc.

1 2 3 4 5 6 7 8 9 10

never occasionally sometimes often always

	a. Child care functions	b. Assessing child	c. Self-awareness aspect
1. Before training			
2. Three months after training			
3. Six months after training			

If there is no increase in your levels of response following training, your thoughts on the reasons for that will provide the trainer with help in changing the training so others will benefit more from it.

CHILD CARE FUNCTIONS IN A CRISIS

I. THE BEGINNING PHASE

7

A. Assessment

1. What do we know about the child?
   Is this a clue to a behavior pattern?
   Where is the child developmentally?
   What issues, times, children, etc., seem to trigger tense responses in this child?
   Where is the child in the process of dealing with separation from home and family?

2. What do we know about ourselves?
   What kinds of reactions do specific behaviors (swearing, fighting, complete withdrawal, sexual acting out, etc.) trigger in us?
   How do we feel about our authority role and taking complete control of a child?

B. Timing

1. Can we verbally intervene now or utilize some other simple distraction or intervention technique (see Redl's list) and prevent the situation from turning into a crisis, or should we wait and let the child try to handle it himself?

II. THE MIDDLE PHASE

A. Taking Control

1. Direct verbal commands and/or

2. Physical intervention (removing a child, etc.) and/or

3. Physical restraint or holding - taking over complete control until you are able to give it back to the child. (This restraint is usually the last resort.)

B. Giving Control Back to the Child

1. Sending a child to his room where he is expected to gain control of himself or
2. In a restraint situation, gradually, limb by limb, giving a child back control of his own body.

III. THE FINAL PHASE

A. Follow-Through and Resolution

1. Life-space interview
   - discuss the child's and your feelings about the incident
   - suggest alternate ways of handling the situation in the future
   - provide hope by setting a short-term attainable goal with the child

2. Possible ways of using routines and activities to help the child avoid crisis-level acting out.

3. Possible ways to use peer group to help child avoid crisis-level acting out.

THREE CRISES: ROLE PLAYS

First Crisis

Participants:

Sam (or Sally) - Age ten years. A new intake at agency, this is his third day. He came to agency from foster home and has a history of multiple placements. He has been mostly "honeymooning" the last two days, but is very restless at night.

Rob (or Rebecca) - Child Care Worker. First contact with Sam.

On-Call Person

Situation:

After dinner. Children usually go to bathroom, then room for rest period. Sam goes right to room. Shortly thereafter, Sam asks to go to bathroom; Rob tells Sam he should go before rest period, but to go ahead this time. After returning to his room, Sam makes issue over the door being open; Rob wants it closed. Situation develops into a power struggle over door. Sam becomes destructive, shouts obscenities. Rob becomes progressively more angry at Sam - gives messages like "I don't allow such behavior..." and threats like extra rest period time, etc. Sam runs out of cottage. Rob apprehends Sam and physically returns him to cottage. On-call person called to remove Sam. Sam leaves with the on-call person.

Second Crisis

Participants:

Tim (or Tina) - Age fifteen years. Has been in placement about nine months. Free for adoption, but no effort has been made to date to seek a family. Initial adjustment to placement difficult with a lot of acting-out behaviors, but for last couple of months has had few behavior problems; is generally cooperative, but is somewhat of a loner.

Micky - Sixteen years old. A follower

Charlie - Child Care Worker

Situation:

Charlie discovers Tim and Micky engaged in mutual sexual play in Tim's room. Both are startled by Charlie's appearance and stop immediately. Micky leaves room. Tim was involved in similar incidents recently with other boys. Charlie tells Tim that he knows what was going on and that he does not consider it appropriate behavior. Charlie tells Tim he is too young to make good judgments regarding sexual involvement with others. Tim denies involvement and acts very silly. Charlie ignores denials and silliness, says masturbation is not wrong, but needs appropriate time and place (bedtime, for example) and should not involve others. Tim continues to be silly and avoid issue as much as possible. Charlie leaves room.

Third Crisis

Participants:

Bill (or Billie) - Age eleven. In placement about one year. A history of multiple placements in various foster homes and agencies. Had a lot of difficulty establishing relationships with adults at first, but now has made close ties with one or two staff members and feels safe with others. Now free for adoption, and a family is actively being sought. Recently a couple of other children have been discharged from Bill's group to adoptive homes.

Denise (or Don) - Child Care Worker

Two or Three Other Children

Situation:

Group including Bill returns from school. Bill is bossy, telling others what to do (change clothing, clean room, be quiet), yet does not do so himself. Other kids get angry at Bill and tease him about his weight problem. Bill begins striking out at others.

Denise breaks it up and eases Bill to couch. She asks Bill what is going on; Bill makes feeble excuses. After a while, Denise suggests Bill might be thinking about kids who had left, and Bill acknowledges this. Denise and Bill discuss Bill's fear of leaving a safe place and leaving people who have become significant to him. Bill cries; Denise provides some positive physical attention and reassures Bill he will not be abandoned; that staff will be sure to find the right place for Bill.

TECHNIQUES FOR CRISIS INTERVENTION

Below is a list of techniques or methods that can be used in dealing with crisis situations.* These are offered as ways of stopping specific behaviors at a given time and are not necessarily intended as continuous or long-range techniques. There are limitations and disadvantages in many of these approaches. They are provided primarily to induce thought on alternative methods of crisis intervention.

1. Planned Ignoring - Since some behavior of children has the goal of getting attention, not providing that attention often stops the behavior. A good dose of positive attention for acceptable behavior in conjunction with the planned ignoring of undesirable behaviors is a powerful combination.

2. Signal Interference - Often, a nonverbal low-keyed sign of disapproval is enough to stop a behavior; for instance, snapping fingers, shaking head "no," looking over the top of your glasses with a frown.

3. Proximity or Touch Control - This is the arm around the shoulder or holding of hands that lets a child know you are there and concerned; it helps define limits.

4. Involvement in Interest Relationship - Often negative behaviors stem from a particular situation or problem. Being interested in the situation or problem reassures the child that he does not have to cope with it alone and often eliminates the undesirable behaviors.

5. Hypodermic Affection - This is a shot in the arm of affection; sitting on a lap or a hug or kiss lets a child know you care for him and can eliminate unwanted behavior.

6. Tension Decontamination Through Humor - Telling a joke, making a tense situation funny, or tickling often stops acting-out behaviors, especially when the group is involved.

7. Hurdle Help - Often children get involved in frustrating problems that are not a part of their particular pathology. Solving the problems for them can alleviate a lot of difficulty.

8. Interpretation as Interference - Sometimes explaining exactly what is happening in a situation or correcting misinformation can "cure" problem behaviors.

* From Fritz Redl and David Wineman, Controls from Within (Glencoe, Ill.: The Free Press, 1952). Used by permission.

9. Regrouping - Activities and games often require teams or groups working together. This can cause friction and acting out behaviors. Simply regrouping the groups can often decrease friction and alleviate the problem.

10. Restructuring - Changing the rules frequently makes a game less frustrating; changing the rules can similarly make life easier to take.

11. Direct Appeal - Once a child has developed a certain amount of ego strength, a direct appeal like "please stop" can stop a negative behavior.

12. Limitation of Space and Tool - By taking away a toy that's being used inappropriately or by not allowing a child in a certain area, a problem can be eliminated; however, we should be cautious of this approach since it relieves the child of the responsibility for self-control and might prevent growth.

13. Antiseptic Bouncing - Removing a child from a situaton in which he is acting out is an effective means of control but subject to the same cautions as limitation of space and control.

14. Physical Restraint - This is a last resort technique to be used after other methods of behavioral interference have failed. The safety of the child is primary: he should never be hurt or scared. The object of physical restraint is to take control only until the child is again able to assume control. Reassuring messages are a must.

15. "Authoritative Verbot" - In this technique the child care worker involves himself in a power play, makes use of the fact that he is the "boss," and demands cessation of negative behaviors. Often this is accompanied with a lot of noise. Unfortunately, it is the most commonly used technique especially among inexperienced staff. The same caution that applied to number 12 and 13 applies here too, only much more so.

16. Promises and Rewards - These, along with punishment and threats, are the most directly related to the reinforcement of learning.

17. Punishments and Threats - These, along with promises and rewards, are the most directly related to the reinforcement of learning.

Stress and Burnout

by Wayne Ouderkirk and Patricia Perfetto

INTRODUCTION

The harmful effects of excessive stress can be prevented. There has long been a small body of literature on the subject, but the past ten years have seen an explosion of serious research, popular books, and lengthy discussions on all levels and in many professions. Child care workers know their job can be stressful. This module provides a framework within which they can become aware of the sources of stress in their own lives. More important, this module gives workers an opportunity to examine their own ways of coping with stress and to assess the effectiveness of those methods. Finally, there is a chance to look at ways of dealing with stress that can provide an important supplement to their own techniques.

One important consideration for trainers: many times the child care position is made more stressful by tasks and responsibilities that are not properly those of child care. In order to have a constructive session, the trainer must make it safe for the worker to identify publicly those other administrative sources of stress. We have found, in some cases, the presence of supervisors or administrators has inhibited such identification, especially when the training group is all from the same agency. Without a safe atmosphere, the training will simply add to stress, rather than reduce it. Given a chance to identify all the causes of stress in their jobs, workers often devise very imaginative solutions to long standing issues. But the safety must be provided by the trainer.

BEHAVIORAL OBJECTIVES

After completing this training session, participants will be able to

1. Distinguish between stress and stressors.
2. Identify stressors in their lives, both at work and at home.
3. Recognize symptoms of stress and burnout.
4. Give specific examples of stress-reducing strategies within each of the general categories of self-management, organizational improvement, and creation of support groups.

BEHAVIORAL CHANGES

1. Participants will take action to reduce their own stress reactions. These actions will be taken both on the job and away from the job.
2. Participants will recognize the signs of stress and burnout in co-workers and assist them in stress reduction.

RESOURCE PAPER: STRESS AND BURNOUT

As the title of this module implies, there is a relationship between stress and burnout; but the two are not identical. For our purposes, we will use Selye's distinction between stressors and stress.[1] When speaking casually, we often use the word "stress" to refer to both; here the distinction will be maintained. Stressors are the factors outside the individual that stimulate the individual's stress reaction. Stress, on the other hand, is the personal physiological and psychological reaction, characterized on the physical level by increases in such bodily functions as heart rate, blood pressure, adrenalin secretion, and respiration, and on the psychological level by behavior designed to eliminate the stressor in such ways as escaping, ignoring, confronting, or overcoming.

Burnout, as discussed here, refers to the state of a person who has endured an excess of stress for a length of time sufficient to exhaust that person's emotional and/or physical reserves. Burnout is not to be confused with a momentary emotional low point. As is the case with any new phrase that does not have a totally fixed reference, burnout has become a catchword for all sorts of things it is not. Freudenburger[2] has called it the burnout syndrome; and that is an apt characterization, since a syndrome is a concentration of several or all of a group of symptoms, no one of which alone indicates presence of the problem. A worker with burnout is one whose ability to continue quality service is severely reduced and perhaps eliminated, because of the intensity and excessiveness of the demands of the job. These demands are, of course, seen as stressors and the reactions the worker has to them are stress.[3]

There seem to be two general approaches to the relationship between stress and burnout. On the one hand, there is the view that, given a stressful job such as child care work, burnout is inevitable. This position implies that, although one can learn various techniques to deal with stress and hence reduce its immediate effects, this simply postpones the inevitable. On the other hand, there is the view that, through stress reduction in all its various forms, it is possible to prevent the incidence of burnout.

While this paper assumes the second view - namely, that burnout in child care work is preventable - it does so because of a specific concept of child care work. That view, not presented here, includes the thesis that the effects of many of the stressors operating on child care workers can be greatly reduced by proper education, training, and other stress reduction methods, and that the effects of many other such stressors can be eliminated because their origins lie in child care work's being in practice the low position on the child welfare totem pole. Without entering into the debate about the second part of this thesis, we will give a timeworn example of such a stressor.

It is common for child care workers to experience situations in which they must deal with behavior problems from other contexts of the milieu. Senior worker John Doe, busily planning the week's activity program, is called to the on-campus school to control the aggression of a boy from his cottage. On rare occasions such a call may be necessary. But at some agencies it happens so frequently that teachers are allowed to abdicate their role in life-space intervention. The result is that the child care worker is perceived by the child as the "heavy," the enforcer of discipline. Since he was not present for the whole incident, he cannot adopt a thoroughly therapeutic stance. The children come to know, "When I'm in trouble in school, my worker handles the discipline." The consequences are an added burden for child care workers, less effective teamwork, and professional conflicts.

Whether or not the reader agrees with this analysis of a part of the child care profession, it remains clear that the role is a stressful one. After examining how burnout can result from excessive stress, we will list many of the behavioral and physiological symptoms that comprise the burnout syndrome. Finally, we will look at ways of reducing stress.

The process of burnout is portrayed graphically in the diagram on p. 403. Stressors fall into two main categories: specific events and ongoing conditions. Both categories are self-explanatory, and both include a large number of potential stressors. What needs to be pointed out about stressors is that they cut across our usual good-bad, positive-negative dichotomies. This follows from Selye's definition of stress as "the nonspecific response of the body to any demand."[4] In his view, based on his lifelong research, the body reacts in much the same way to any demand. So positive demands must be viewed as stressors also. This accords well with common experience. We are all familiar with the tension with which people approach a new job or a trip to the dentist's office. The degrees of stress produced may be different, but both must be viewed as stressors.

The next level of the diagram depicts certain aspects of persons and their situations that often reduce or eliminate the personal stress reaction. A convenient way of picturing these factors is to think of them as a series of filters that have varying degrees of effectiveness in filtering out stressors for us. Some are conscious, some not.

The box entitled "stress mediators" includes those things that actually can filter out stressors before we react. For example, personality factors can be a tremendous help here; but only for those with the right personality traits. One child care worker may be able to remain very calm in crisis situations, unfazed by a child's or a group's violent or otherwise threatening behavior. Yet another worker, though completely professional in his or her actions, may be extremely upset by such a situation. Obviously connected with such cases is one's experience. Usually the acquisition of skills and experience can also reduce the stressfulness of situations.

Another influence at this level is the context in which the event occurs. As workers know, it can be much more stressful for a child to have a tantrum in a public place than in the privacy of the agency grounds. Time is a similar kind of factor. The amount of support one has is important. Given a new work assignment by the child care director, a worker may look forward to an interesting task. But if it is a large task or if there is little support, the new assignment becomes a burden. Personality, experience, context, and support are all factors that can mediate stress in various ways.

In some cases, there may not be an appropriate stress mediator, or there may be so many stressors that the stress mediators that do exist cannot filter them out. In such cases, people normally take steps to reduce stress, and that brings us to the next box on our diagram. Even without special training, people make efforts at self-management to reduce stress. One elementary move here is the avoidance, as much as possible, of particularly difficult stressors. Another traditional approach is prayer, through which the individual can often gain a new perspective on the situation. There are others, which we will discuss below. The elimination of organizational stressors is a tremendous reducer of stress. The creation and use of support systems has an obvious bearing on the reduction of stress. The more support a person has in a situation, the less alone and the more confident he feels. (This principle is precisely the same as one practiced by child care workers and other helping professions: the elimination of the client's isolation by increasing support systems leads to improved functioning and the elimination of negative behavior.) These stress reducers will come up again when we discuss how stress can be consciously controlled and burnout prevented.

In the process of burnout, our stress mediators and reducers become overwhelmed. When this begins to happen and stress reaches a very high level, various symptoms start to appear. No one of these symptoms by itself indicates burnout; but the more of them there are, and the longer they are allowed to persist, the more likely they are to result in burnout. On the physical side, there are several symptoms that are familiar to us all as being typical of the harried business executive. But that is simply a stereotype, for these symptoms can arise when anyone, in any profession, is experiencing excessive stress. High blood pressure, increased heart rate, and gastrointestinal problems can affect anyone in such a situation. On the psychological side, those enduring high levels of stress often become depressed or irritable, insomniac, and less effective in their jobs.

If these symptoms arise and are not responded to by the individual, they become stressors. This tremendously significant fact is reflected in the diagram by the dotted arrow that returns to the stressor level. If one has been unable to sleep because of stress, the inability to sleep becomes an added stressor.

In addition, exhaustion interferes with effectiveness. Because the symptoms of stress increase the number of stressors, stress reduction includes trying to reduce symptoms as well as eliminating stressors.

if the cycle goes unchecked, the outcome is burnout. The ultimate burnout is death. Most of us have heard of stress-induced cardiac death, though perhaps not among child care workers. Other extreme physical symptoms are bleeding ulcers and chronic high blood pressure. Although we have in mind somewhat less severe physical and psychological symptoms, it is well to remind ourselves of the high risks that stress entails.

Research has found some common characteristics of burned-out workers, giving burnout the status of a syndrome. Fatigue or exhaustion are signs of extreme stress and burnout. So are frequent colds, headaches, gastrointestinal problems (e.g., constant heartburn), extreme loss or gain of weight, and shortness of breath.

As for behavioral signs, changes in usual behaviors are often seen in burnout; the talker on the team becomes increasingly withdrawn, the easygoing member progressively testier. Suspicion and paranoia about supervisors and administrators have also been noted. In some cases, a strange feeling of omnipotence on the job arises. Apparently the person involved has been through so many crises that he feels he can handle anything. This can lead to unnecessary risks, endangering self, child, and programs.

Extreme rigidity becomes the refuge of the burned-out worker. Even minor changes are met firmly with by-the-book responses. This rigidity appears as a defense against any kind of demand that might become a new stressor. One of the most frightening, debilitating effects and signs of burnout for the child care worker is the appearance of a cynical attitude toward children and child care. Since most child care workers enter the field with a positive regard for the children and a genuine interest in helping, such cynicism can be very upsetting when workers become aware of it in themselves.

Often workers will try to cope with their decreased effectiveness resulting from stress by spending more time on the job. But this produces a continuing decrease in overall effectiveness. Inevitably, all these reactions affect the individual's personal life. Job problems have a way of coming home with the worker and can result in new or worsened personal problems.

Thus, we see that the adverse effects of stress include a decreased ability to provide care for children, diminished physical health,[5] stunted personal growth, and low satisfaction. Obviously a great deal needs to be done to prevent such devastating results. The efforts at preventing burnout can occur at three different levels: self-management, organizational improvement, and support systems.

Since the handout on page 406 lists various kinds of stress management techniques, the discussion here will be more general. The main point of such techniques is that individuals have to be actively involved in dealing with their own reactions to stressors. A large dose of self-awareness and honesty is crucial here. Once one is sure of the causes of stress, there are often concrete steps one can take to do something about them. Essentially, one cannot let stress be; demands must be answered, but in answering them one must take care of oneself.[6]

Vattano has provided an illuminating discussion of three formalized procedures for coping with stress - relaxation training, systematic desensitization, and meditation. He also mentions, but doesn't discuss, biofeedback training, which "teaches people to voluntarily control certain physiological responses associated with stress and anxiety."[7] The major common element of these four structured forms of self-management is that the individual can exercise control over his or her own stress responses. It cannot be emphasized enough that such conscious self-control is a crucial element in anyone's attempt to reduce stress.

Additionally, it also is necessary to take active steps to care for one's body. Regular exercise and commonsense health habits such as no smoking, proper eating, and sufficient sleep are significant factors in preventing the deterioration of the body from stress. It may seem condescending to call adults' attention to such elementary notions as good health habits. However, the stress research as well as personal experience has shown that professionals in stressful positions tend to neglect such basic self-care principles. At times, we child care workers seem to exist on coffee and cigarettes! So it seems very much to the point to call attention to health habits as an important component of stress management.[8]

But self-management alone cannot do the job in the presence of unnecessary stressors. Child care is not unique in requiring some internal change as well as alterations in relation to other professions. However, it has a long way to go. Many times such problems as the worker being called frequently to the classroom, as mentioned earlier, can be eliminated very constructively. In one presentation of a training session on stress and burnout, there was an excellent cross section of people from various levels of the field of child welfare. When child care workers complained of such unnecessary stressors and it was suggested that they take their complaints to the administrator, an agency director responded. He pointed out that he looks askance at such complaints, since they represent increased demands -- stressors -- for him. But if workers were to come to him with a problem and a suggested change or changes, he would be more open to implementing change. The point of the anecdote is that if workers suggest thought-out ways of changing agency systems, they have a better hope of success.

Another "organizational" improvement child care workers need is to stake out their professional role in the child welfare system. Although this is a large task, there are steps individual workers can take. They can join professional child care organizations, participate in conferences of their own and other professions, educate their communities, and participate in the relevant political process that influences their jobs, agencies, and clients. The overall result of such steps will be a definition of the child care role and the reduction of stressors resulting from the presently existing ambiguity about it.

Joining professional organizations has a double function in stress reduction. Not only does it represent an effort to change the system, but it also links the child care worker with a professional support group. Support groups function in many ways. Within an agency, it is possible to form a group, either formally or informally, for the purpose of helping one another deal with stress. Just the opportunity to talk safely about one's reaction can relieve some stress. At such meetings, workers can share methods of coping with stress as well as effective child care techniques.

One final, highly significant support system must be mentioned. It is personal. Each of us, as a person, needs to love and be loved. Without such a human support, our lives are diminished. No matter whom we love and who loves us, the acceptance we gain in such a relationship underpins all our efforts to function at our optimum.

Through the various categories of stress reduction techniques, we attempt to deal with both symptoms (stress) and cause (stressors). We have not discussed child care education as a stress reducer, though it can function in that way by eliminating the uncertainty about what to do when. Combined education and stress reduction will result, we believe, in the prevention of burnout. This will result in the improvement of child care.

References (see pp. 399-400 for full listings)

1. Hans Selye, The Stress of Life (New York: McGraw Hill, 1956): pp. 54-64.

2. Herbert J. Freudenberger, "The Staff Burn-Out Syndrome in Alternative Institutions," pp. 73-82.

3. This definition of burnout may seem overly dramatic to some readers. But it has not seemed so to the over three hundred child care and social workers who have participated in training sessions in which it was used.

4. Selye, Stress Without Distress (Philadelphia: Lippincott, 1974): p. 27. In this work Selye distinguishes stress from distress, the latter being "damaging or unpleasant stress" (p. 31). Distress so defined comes close to the concept of burnout used in this paper.

5. Thomas H. Holmes and T. Stephenson Holmes, "How Change Can Make Us Ill," in Stress, Blue Print for Health 25, no. 1. (1974), pp. 66-76. Also Thomas H. Holmes and Richard H. Rahe, "The Social Readjustment Rating Scale," Journal of Psychosomatic Research 11, pp. 213-218. Some limitations of this approach are pointed out by Lazarus in the interview cited below (6).

6. It is important to note that denial, that much-abused defense mechanism, can in some situations be a constructive, effective response. For a thought-provoking discussion of this and other stress related topics see Richard S. Lazarus (interviewed by Daniel Goleman), "Positive Denial."

7. Anthony J. Vattano, "Self-Management Procedures for Coping with Stress," Social Work 23 (March 1978), p. 113.

8. For a full discussion of health habits in the context of a holistic approach to health and prevention of disease and stress, see Donald B. Ardell, High Level Wellness.

SESSION OUTLINE: STRESS AND BURNOUT

Time: About 1 hour, 40 minutes

Space: Large room

Equipment: Overhead projector and screen (optional)

Materials: Handouts:
- "Self-Assessment: Stress and Burnout," p. 402
- "Burnout Through Stress," p. 403 (can be used as overhead transparency)
- "Sources of Stress," p. 404
- "Stress Management Review," p. 405
- "Some Effective Ways to Manage Stress," p. 406
- "Some Readings on Stress," p. 407

1. Introduction and Definitions — 10 minutes

The trainer distributes the handout "Self-Assessment: Stress and Burnout" and asks participants to rate their performance of the activities indicated by writing their responses in the "before training" boxes. The trainer explains the importance of participants' repeating this self-assessment at three months and six months after training. After the final assessment, participants are to return the completed form with their comments to the trainer.

The trainer introduces the topic and its importance for the participants. Then the distinctions between stressors, stress, and burnout are presented, along with their respective definitions. Examples are always helpful.

2. The Process of Burnout — 20 minutes

The diagram "Burnout Through Stress," which can easily be made into an overhead transparency and/or a handout, is explained. The explanation should include relevant examples from child care work. This part of the session is very lecturelike, but usually participants break into the presentation with questions and observations. The symptoms of burnout are presented here, as in the resource paper, as the outcome of this process.

3. Identifying Stressors — 10 minutes

a. The handout "Sources of Stress" can be useful here or participants can simply make lists. Since the purpose of this activity is for them to identify the stressors that exist in their lives, they have to know that their lists are for their own use only. This helps provide safety for them. They are simply to list the stressors which they can think of, both specific events and ongoing conditions, on the job and away from the job.

5 minutes

b. If they wish, they can share their on-the-job stressor list with a neighbor. (A large group discussion of stressors could be added or substituted here.)

4. Managing Stress 10 minutes

a. On the "Stress Management Review," participants are to list their means of dealing with their own stressors. In addition, they are to classify their responses to stress as constructive or destructive, or effective or ineffective. (Case examples of stressful situations and/or burned-out workers could be used to illustrate the differences between effective and ineffective stress reduction techniques and as a prelude to the participants' identification of their own techniques. The participants could be asked to identify the stressors and the behavioral signs of stress and burnout, to classify techniques being used, and to give suggestions for change. Such an exercise would lengthen the session by at least 40 minutes. If used, it should not substitute for the participants' evaluation of their own coping.)

10 minutes

b. The trainer can ask volunteers to share their ineffective coping techniques. Participants usually enjoy doing this, since it reveals our common foibles. The trainer can reveal a few of his/her own to help the discussion along.

5. New Strategies 20-30 minutes

The discussion of ineffective techniques usually leads without demarcation to a discussion of effective techniques. The outline of "Some Effective Ways to Manage Stress" is intended as a handout to go with this discussion. Often a group of twenty to thirty will come up with almost everything on the sheet. That way the outline serves as a summary. On other occasions the trainer may have to use the handout as the focus for the discussion.

6. Conclusion 10 minutes

The trainer should end the session on an upbeat note, since the session is designed to encourage people to deal constructively with their own stress as well as with stressors, thereby preventing burnout. This can be accomplished by asking the group to write individual "I learned" statements and soliciting volunteers to share their statements. The handout "Some Readings on Stress" can be given out at this time to encourage participants to look further into the subject.

ANNOTATED BIBLIOGRAPHY

Ardell, Donald B. High Level Wellness. Emmaus, Pa.: Rodale Press, 1977.

An easily readable, recent discussion of various health factors, one of which is stress managment. Others include such essentials as self-responsibility, nutritional awareness, and physical fitness. Probably the most important message of this work is that it places the responsibility and the capability of maintaining well-being on the reader. From that viewpoint, it is optimistic about the individual's ability to control his or her own stress reactions.

Benson, Herbert. The Relaxation Response. New York: Avon, 1975.

Gives a readable discussion of the benefits of relaxation and an interesting description of the common elements of meditation as found in diverse spiritual traditions.

Bramhall, Martha, and Ezell, Susan. "How Burned Out Are You?" Public Welfare, winter 1981, pp. 23-27.

The first of a three-part series, this article is a good brief discussion of how individuals can assess the degree of burnout they have experienced. It includes a questionnaire for rating the degree of stress. Subjects of parts two and three: a personal regimen for treating burnout and what organizations can do to prevent burnout.

Edelwich, Jerry, and Brodsky, Archie. Burnout: The Stages of Disillusionment in the Helping Professions. New York: Human Sciences Press, 1980.

Cited by Bramhall and Ezell, but not reviewed by us. However, judging by the title, it promises to be a useful source book of ideas.

Freudenberger, Herbert J. "The Staff Burnout Syndrome in Alternative Institutions." Psychotherapy: Theory, Research and Practice 12 (spring 1975).

Contains an explicit description of burnout. Though the institutions he speaks of here are not traditional child caring institutions, most aspects of the discussion are pertinent in one way or another to child care. Recommended for both workers and trainers.

Lazarus, Richard S. "Positive Denial: The Case for Not Facing Reality." Interview by Daniel Goleman. *Psychology Today*, November 1979.

An interesting and balanced examination of stress and stress management. It is of interest to anyone who wants to understand the most recent approaches to stress research. A very good stimulus for discussion.

Maslach, Christine. "Burned-Out." *Human Behavior*, September 1976.

Another high quality and readable description of burnout. Probably the best article to use as an introductory reading.

Mattingly, Martha A., ed. "Symposium: Stress and Burnout in Child Care." *Child Care Quarterly* 6 (summer 1977).

Includes articles by Mattingly, Maslach, Freudenberger and others. The first published discussion of burnout in the child care profession. Includes discussions of the cases, symptoms and suggested plans of prevention for various child care settings.

Selye, Hans. *The Stress of Life*. New York: McGraw-Hill, 1978. *Stress without Distress*. New York: Signet, 1974.

In these two books, Selye, the premier stress researcher, discusses the findings of years of research into the problem. He describes the general adaptation syndrome (G.A.S.); distinguishes stressors, stress, and distress; and provides insight into our contemporary behavior patterns that produce distress. In spite of Selye's research sophistication, these books are written for the general reader.

Vattano, Anthony J. "Self Management Procedures for Coping with Stress." *Social Work* 23 (March 1978).

Highly recommended. An excellent discussion of relaxation training, systematic desensitization, and meditation as stress reducing techniques for use with clients. Obviously such techniques are helpful for practitioners also.

HANDOUTS

SELF-ASSESSMENT: STRESS AND BURNOUT

Filling out this form will enable you to determine the effects of the training on your job performance. It can also provide your trainer with valuable data that may be useful in improving future training.

Rate your performance on the following items. Choose the number on the scale that most closely represents your level of activity for each item. Write that number in the proper box below. Repeat at three months and again at six months following training.

a. I make an effort to determine what are the sources of stress in my life and how I respond to them.

b. I make an effort to utilize all the stress-reducing strategies available to me (self-management, organizational, and support group strategies).

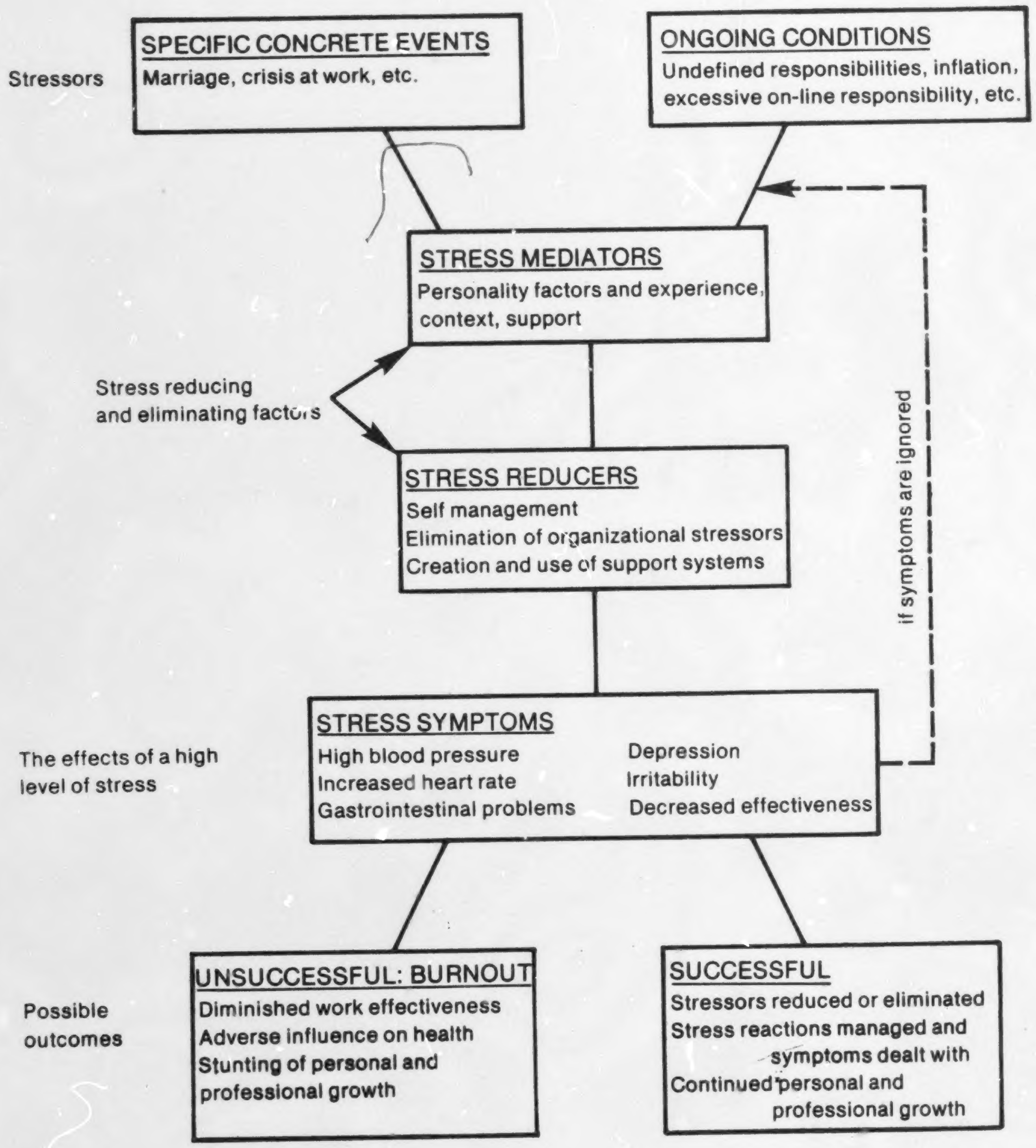
c. I make an effort to create new stress-reducing strategies for myself and fellow workers.

1	2	3	4	5	6	7	8	9	10
never		occasionally		sometimes			often		always

	a. Sources of my stress and my response	b. Use of stress reduction strategies	c. Creation of new strategies
1. Before training			
2. Three months after training			
3. Six months after training			

If your performance does not improve following training, try to figure out why and share the explanation with your trainer. Your experience could benefit future participants.

BURNOUT THROUGH STRESS


Stressors
SPECIFIC CONCRETE EVENTS
Marriage, crisis at work, etc.
ONGOING CONDITIONS
Undefined responsibilities, inflation, excessive on-line responsibility, etc.
STRESS MEDIATORS
Personality factors and experience, context, support
Stress reducing and eliminating factors
STRESS REDUCERS
Self management
Elimination of organizational stressors
Creation and use of support systems
if symptoms are ignored
The effects of a high level of stress
STRESS SYMPTOMS
High blood pressure
Increased heart rate
Gastrointestinal problems
Depression
Irritability
Decreased effectiveness
Possible outcomes
UNSUCCESSFUL: BURNOUT
Diminished work effectiveness
Adverse influence on health
Stunting of personal and professional growth
SUCCESSFUL
Stressors reduced or eliminated
Stress reactions managed and symptoms dealt with
Continued personal and professional growth

SOURCES OF STRESS

	AT WORK	AWAY FROM WORK
RECENT EVENTS		
DAY TO DAY CONDITIONS		

STRESS MANAGEMENT REVIEW

	ON THE JOB	AWAY FROM WORK
EFFECTIVE		
INEFFECTIVE		

SOME EFFECTIVE WAYS TO MANAGE STRESS

1. Stress Management

   A. Physical:
   Vigorous Regular Exercise
   Appropriate Sleep and Nutrition

   B. Spiritual:
   Relaxation/Meditation/Centering
   Unhooking

   C. Self-Awareness:
   Needs, Desires, Idiosyncracies
   Congruence/Assertiveness

   D. Personal Planning:
   Sequencing/Scheduling/Prioritizing
   Shielding
   Proactive Life Choices

2. Creation and Use of Support Systems

   A. On the Job

   B. Away from the Job

3. Altering Stressful Organizational Norms, Policies, and Procedures and Building-in Organizational Stress Mediators

   A. Problem Solving Individually and with Others

   B. Proposing Constructive Solutions within the Agency

SOME READINGS ON STRESS

Ardell, Donald B. *High Level Wellness*. Emmaus, Pa.: Rodale, 1977.

Benson, Herbert. *The Relaxation Response*. New York: Avon, 1975.

Bramhall, Martha, and Ezell, Susan. "How Burned Out Are You?" *Public Welfare*, winter 1981, pp. 23-27 (first of a three-part series).

Edelwich, Jerry, and Brodsky, Archie. *Burnout: Stages of Disillusionment in the Helping Professions*. New York: Human Sciences Press, 1980.

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Holmes, Thomas H., and Rahe, Richard H. "The Social Readjustment Rating Scale." *Journal of Psychosomatic Research* 11 (1967), pp. 213-218.

Lazarus, Richard S. "Positive Denial: The Case for Not Facing Reality." *Psychology Today* (November 1979), pp. 44ff.

Maslach, Christina. "Burned-Out." *Human Behavior* (September 1976), pp. 16-22.

Mattingly, Martha A., ed. "Symposium: Stress and Burnout in Child Care." *Child Care Quarterly* 6 (summer 1977). (Includes articles by Mattingly, Maslach, Freudenberger, and others.)

Rahe, Richard H., et al. "Social Stress and Illness Onset." *Journal of Psychosomatic Research* 8 (1964), pp. 35-44.

Selye, Hans. *Stress Without Distress*. New York: McGraw-Hill, 1978.

Vattano, Anthony J. "Self Management Procedures for Coping with Stress," *Social Work* 23 (March 1978).